| BLADDER | ❑ Completed by:_____ Date:_____ |
|---|---|
| Issues from Pt. Checklist | ❑ Repeated symptomatic UTI ❑ Hematuria<br>Other _____ |
| Exam Findings | CSU — Date:_____ Result:_____<br>Urodynamics[1] — Date:_____ Result:_____<br>Renal ultrasound[2] — Date:_____ Result:_____<br>Cysto (if indicated) — Date:_____ Result:_____ |
| Management Plan | ❑ Evaluate knowledge of UTI signs & symptoms<br>❑ Prescribe supply of broad-spectrum antibiotic_____ |
| Referral | ❑ _____ |

| BOWEL | ❑ Completed by:_____ Date:_____ |
|---|---|
| Issues from Pt. Checklist | ❑ Chronic constipation ❑ Rectal bleeding<br>Other _____ |
| Exam Findings | Physical:_____<br>Anorectal trauma/hemorrhoids stage:_____<br>Colonoscopy (if indicated) — Date:_____ Result:_____ |
| Management Plan | ❑ Counsel on bowel program _____<br>❑ Other:_____ |
| Referral | ❑ _____ |

| SKIN | ❑ Completed by:_____ Date:_____ |
|---|---|
| Issues from Pt. Checklist | ❑ History of pressure ulcers _____<br>Other _____ |
| Exam Findings | Physical: Pressure ulcers<br>*Area* *Stage* *Date & Origin*<br>_____ _____ _____<br>_____ _____ _____<br>Modified Braden Scale: _____ |
| Risk Factors | ❑ Skin moisture<br>❑ Function/transfers<br>❑ Old equipment<br>❑ Poor nutrition/anemia<br>❑ Smoking<br>❑ Alcohol > 4 drinks/day<br>❑ Substance abuse<br>❑ Investigate for incontinence<br>❑ Investigate reason/refer to OT<br>❑ Refer to OT<br>❑ Check FBC, albumin, Zn, Mg<br>❑ Advise to stop<br>❑ Review alcohol intake (CAGE)<br>❑ Review further |
| Management Plan | ❑ Counsel on prevention _____<br>❑ Other:_____ |
| Referral | ❑ _____ |

| SEXUAL | ❑ Completed by:_____ Date:_____ |
|---|---|
| Issues from Pt. Checklist | _____<br>_____ |
| Management Plan | ❑ Fertility clinic ❑ (M) PDE5 Inhibitor_____<br>❑ (M) Vibro/electro-ejaculation ❑ Other:_____ |
| Referral | ❑ _____ |

**Recommended follow-up post SCI**

[1] – At 3 months, 6 months, then annually
[2] – At 6 months, then annually
[3] – Annually, or as indicated
[4] – At 3 months, then annually

| CARDIOVASCULAR | ❑ Completed by:_____ Date:_____ |
|---|---|
| Issues from Pt. Checklist | _____<br>_____ |
| Exam Findings | Pulse: _____ Auscultation:_____<br>BP Supine: _____ Sitting: _____<br>Fasting BSL/TG/Cholesterol: Date:_____<br>BSL:_____ TG:_____ C'ol:_____ |
| Management Plan | ❑ Prescribe GTN spray or anginine tablet _____<br>❑ Give Pt. AD mgmt. wallet card ❑ Arrange MedicAlert<br>❑ Diet/exercise counsel: _____ |

| RESPIRATORY | ❑ Completed by:_____ Date:_____ |
|---|---|
| Issues from Pt. Checklist | _____<br>_____ |
| Exam Findings | PFT[2] Date:_____ Result:_____<br>Vital Cap Date:_____ Result:_____<br>Auscultation Result:_____ |
| Management Plan | ❑ Epworth Sleep Scale ❑ Sleep Study (if ind.)<br>❑ Fluvax (q1yr—Date last:_____) ❑ Pneumovax (if ind.) |
| Referral | ❑ _____ |

| NEURO | ❑ Completed by:_____ Date:_____ |
|---|---|
| Issues from Pt. Checklist | ❑ Change in function ❑ Previous syrinx<br>Other _____ |
| Exam Findings | Neuro Function[3]:_____<br>MRI Date:_____ Result:_____ |
| Referral | ❑ _____ |

| PAIN | ❑ Completed by:_____ Date:_____ |
|---|---|
| Issues from Pt. Checklist | ❑ Neuropathic — area(s): _____<br>❑ Nociceptive — area(s): _____<br>Other _____ |
| Exam Findings | Physical:_____ |
| Management Plan | ❑ Pain clinic ❑ Other _____ |
| Referral | ❑ _____ |

| MUSCULOSKELETAL | ❑ Completed by:_____ Date:_____ |
|---|---|
| Issues from Pt. Checklist | ❑ Hx of fractures ❑ Spasm (problematic)<br>Other _____ |
| Exam Findings | BMD[4] Date:_____ Result:_____ |
| Management Plan | ❑ Osteoporosis prev'n (incl' bisphosphonates)_____<br>❑ Other:_____ |
| Referral | ❑ _____ |

| GENERAL HEALTH | ❑ Completed by:_____ Date:_____ |
|---|---|
| Issues from Pt. Checklist | ❑ Depression ❑ (F) Pap smear & mammogram<br>Other _____ |
| Management Plan | ❑ _____ |
| Referral | ❑ _____ |