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| Bowel Charting   |  |  | | --- | --- | | **Participant’s Name:** |  | |

**Please fill out each time client has a bowel motion no matter how big or small. Please look at clients stomach daily for signs of constipation – does their stomach feel soft or hard and are they overly bloated? If client is showing symptoms of constipation or they have gone over 24 hours without a bowel motion, please call Karyn O’Brien immediately. The client’s doctor will be called for advice.**

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| **Date** | **Time** | **Comments**  **i.e. volume, blood, mucous**  S = Small  M = Medium  L = Large | **Type 1**  **0** | **Type 2** | **Type 3** | **Type 4** | **Type 5** | **Type 6** | **Type 7** | **Staff Initials** |
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