|  |  |  |
| --- | --- | --- |
| 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.**

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Date** | **Time** | **Comments** **i.e. volume, blood, mucous**S = SmallM = MediumL = Large | **Type 1****0** | **Type 2** | **Type 3** | **Type 4** | **Type 5** | **Type 6** | **Type 7** | **Staff Initials** |
|  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |