

Self-Help Assessment



Print out, complete and share with your doctor to help determine if you have a condition that requires treatment. This assessment will also help you and your doctor determine if UrAssist is a suitable solution for you.

1) Do you have any of the following medical conditions:

| | |
|-------------------------|--|
| Disability_____ | Spinal Cord Injury_____ |
| Limited mobility_____ | Obesity_____ |
| Stroke_____ | Amputation of extremity_____ |
| Wounds or rashes_____ | Arthritis interfering with daily activities_____ |
| Multiple Sclerosis_____ | Post surgery_____ |
| Muscular Dystrophy_____ | Other_____ |

2) Within the past 6 months, have you been in a:

| | | |
|-------------------------------|------------|------------------------------|
| Hospital_____ | Term | Long Term Care Facility_____ |
| Rehabilitation Facility_____ | Other_____ | |
| Assisted Living Facility_____ | | |

3) Do you use any of the following:

Cane_____ Walker_____ Wheelchair_____ Mobility scooter_____

4) Do you have someone who takes care of you? Yes____ No____

5) Have you fallen or slipped on the way to the bathroom? Yes____ No____

6) Have you had problems transferring from a wheelchair to a toilet seat?
Yes____ No____

7) Can you use the toilet independently? Yes____ No____

8) Do you ever have accidental loss of urine? Yes____ No____

9) Do you ever have accidental loss of urine at night? Yes____ No____

10) Do you ever have a sense of urgency to urinate? Yes____ No____

11) Do you wake more than 2 times per night to urinate? Yes____ No____

12) Do you urinate more than 8 times per day? Yes____ No____

13) Do you leak when you sneeze, cough or lift objects? Yes____ No____



Freedom to go.

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14) Do you wear adult diapers or protective pads to avoid leaking? Yes___ No___

15) Do you drink fluids containing caffeine? Yes___ No___

16) Do you avoid leaving the house or participating in activities where bathroom facilities are not readily available? Yes___ No___

17) Do you keep track of your toileting? Yes___ No___

18) Do you have the capacity to control your bladder for 15-30 seconds? Yes___ No___

19) Which of the following best describes your symptoms?

Overactive bladder (frequent, sudden urge to urinate, leak urine) _____

Retention (need a catheter to urinate) _____

Mobility challenges prevent me from getting to the bathroom _____

20) Which of the following best describe your reasons for seeking information about bladder treatments? (You can choose more than one answer).

Medications are not working _____

First time seeking help _____

Don't like medication side effects _____

Other _____

Medications are too expensive _____

UrAssist offers assistance to people with certain mobility challenges and bladder conditions. Since UrAssist is non-invasive (does not attach to or enter the body) it is ready to go when you are. With minimal privacy, you can easily use UrAssist to urinate while in bed or using a wheelchair.

Next steps:

Print, complete and share with your doctor along with the [Letter for your Doctor](#).

This self help assessment is for informational purposes only to share with your doctor. It is not intended to provide or replace medical advice from your physician. If you are experiencing difficulties with your bladder or mobility challenges, please contact your physician immediately.

NOTE: In order for UrAssist to be an effective option, you must be able to feel the urge to urinate, and have the upper extremity function and ability to operate UrAssist.