



Section A: General Study Information for Office Use Only:

A1. Study ID#:

A2. Visit # 4 Months VS06 14 Months VS09
 6 Months VS07 20 Months VS10
 8 Months VS08 26 Months VS11

A3. Date Form Completed: ___ ___ / ___ ___ / ___ ___
 MONTH DAY YEAR

A4. Initials of Person Completing this Form: _____

SECTION B: TREATMENT FOR URGE INCONTINENCE POST-INTERVENTION

B1. Did the patient receive any newly initiated treatment for **urge UI** since her last visit?

- YES 1
- NO 2 → **SKIP TO SECTION C**

B1a. Was UTI ruled out or diagnosed and treated by the MD Investigator or another practitioner prior to initiation of the new treatment for urge UI?

- YES, UTI RULED OUT 1
- YES, UTI DIAGNOSED, TREATED AND RESOLVED 2
- NO 3 → **COMPLETE F290: PROTOCOL DEVIATION**

B2. Did the patient receive newly initiated **drug treatment** for urge UI since her last visit?

- YES 1
- NO 2 → **SKIP TO B3**

B2a. Circle yes or no for all drug treatments newly initiated for **urge UI**:

YES	NO
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Detrol

1↓ 2

a. Date of request to resume drug treatment: ____ / ____ / ____
Month Day Year

b. Reason cited by patient for resuming drug treatment: _____

Other Anticholinergic

1↓ 2

a. Specify: _____

b. Date of request to resume drug treatment: ____ / ____ / ____
Month Day Year

c. Reason cited by patient for resuming drug treatment: _____

B3. Did the patient receive **any other** newly initiated treatment for urge UI since her last visit?

YES..... 1

NO..... 2 → **SKIP TO SECTION C**

B3a. Record all treatments for urge UI newly initiated since the last visit, including the date of treatment and the patient’s reason for requesting the treatment. Treatments include: behavioral treatment, neuromodulation, botox injections, myomectomy, electrical stimulation, other intravesical therapy or any other treatment for urge UI. (See Treatment Codes attached).

	i. TREATMENT	ii. CODE	iii. IF CODE 06 OR 99, SPECIFY :	iv. DATE OF TREATMENT	v. REASON FOR REQUEST
a.				____ / ____ / ____	_____ _____ _____
b.				____ / ____ / ____	_____ _____ _____
c.				____ / ____ / ____	_____ _____ _____

SECTION C: PRINCIPAL INVESTIGATOR’S SIGNATURE

Principal Investigator’s Signature: _____

Date: ____ / ____ / ____
Month Day Year

TREATMENT CODES	
01	Behavioral treatment
02	Neuromodulation
03	Botox injections
04	Myomectomy
05	Electrical stimulation
06	Other Intravesical Therapy
99	Other

BE-DRI