ICDB

Interstitial Cystitis Data Base

Patient ID: ___ ___ ___ ___ ___ ___

Date: ___ ___ / ___ ___ / ___ ___
month day year

Exclusion Checklist # 2

To be completed before CMG:	***yes*** (1)	***no*** (0)
1. Does this patient have GU tuberculosis?	☐	☐
2. Does this patient have neurogenic bladder dysfunction? (*If necessary, this criteria may be assessed after the CMG procedure.)*	☐	☐
3. Does this patient have an urethral stricture? (*If necessary, this criteria may be assessed after the CMG procedure.*)	☐	☐
4. (***Men only %***) Does this patient have prostate cancer?	☐	☐
5. Has this patient had any of the following therapies or procedures: a. Augmentation cystoplasty?	☐	☐
b. Cystectomy?	☐	☐
c. Cystolysis or bladder denervation procedure?	☐	☐
d. Neurectomy affecting bladder function?	☐	☐

Are any shaded boxes checked?

☐$_1$ yes Patient is excluded.

☐$_0$ no Please continue with the screening process.

To be completed after CMG:	***yes***	***no***
6. Does this patient have a bladder outlet obstruction?	☐	☐

Are any shaded boxes checked?

☐$_1$ yes Patient is excluded.

☐$_0$ no Please continue with the screening process.