Form 11: Immediate Post-Operative Measures, Version 07/01/02 (A)

Section A: General Study Information for Office Use Only:

A1. Study ID#: Label

A2. Visit # Surgery.....SURG

A3. Date Form Completed: ___ ___ / ___ ___ / ___ ___ ___ ___
Month Day Year

A4. Initials of Person Completing this Form: ____ ____ ____
(Certified Surgeon)

SECTION B: COMPLICATIONS IN THE IMMEDIATE POST-OPERATIVE PERIOD (PRE-HOSPITAL DISCHARGE)

REMINDER: COMPLETE ADVERSE EVENT FORMS AS REQUIRED

B1. Were any **wound complications** identified in the post-op period?

Yes..... 1

No..... 2 ➔**SKIP TO B2**

Circle yes or no for all types listed:	*YES*	*NO*
a. Separation	1	2
b. Hematoma	1	2
c. Infection	1	2
d. Infected hematoma	1	2
e. Abscess	1	2
f. Hernia	1	2
g. Sling erosion	1	2
h. Seroma	1	2
i. Other	1🡻	2
Specify: _____		

B1j. Were there any treatments for post-op wound complications?

Yes..... 1

No..... 2 ➔ **SKIP TO B2**

B1k. Describe any treatments for any post-op wound complications: _____

_____

_____

B2. Were any **organ injuries** newly identified in the post-op period?

YES 1

NO ..... 2 ➔ **SKIP TO B3**

Circle yes or no for all types listed:	***YES***	***NO***
a. Bladder injury	1	2
b. Urethral injury	1	2
c. Ureteral injury	1	2
d. Fistula	1	2
e. Intestinal injury	1	2
f. Rectal injury	1	2
g. Vascular injury	1	2
h. Nerve injury	1🡻	2
Specify: _____		
i. Other	1🡻	2
Specify: _____		

B2j. Were there any treatments for post-op organ injury complications?

Yes..... 1

No..... 2 ➔ **SKIP TO B3**

B2k. Describe any treatments for any post-op organ injury complications: _____

_____

B3. Did the patient experience **acute renal failure** in the post-operative period?

Yes..... 1

No..... 2 ➔**SKIP TO B4**

B3a. Were there any treatments for acute renal failure?

Yes..... 1

No..... 2 ➔ **SKIP TO B4**

B3b. Describe any treatments for acute renal failure: _____

_____

_____

Affix ID Label Here

B4. Were any **cardiovascular complications** newly identified in the post-op period?

Yes..... 1

No..... 2 ➔**SKIP TO B5**

Circle yes or no for all types listed:		***YES***	***NO***
a.	Deep vein thrombosis	1	2
b.	Myocardial infarction	1	2
c.	Cerebrovascular accident	1	2
d.	Other	1🡻	2
	Specify: _____		

B4e. Were there any treatments for any post-op CV complications?

Yes..... 1

No..... 2 ➔ **SKIP TO B5**

B4f. Describe any treatments for any post-op CV complications: _____

_____

B5. Were any **febrile morbidities** identified in the post-op period?

Yes..... 1

No..... 2 ➔**SKIP TO B6**

Circle yes or no for all types listed:		***YES***	***NO***
a.	Unexplained fever: ≥ 101˚f (38.3 ˚C)	1	2
b.	Pelvic cellulitis	1	2
c.	Urinary tract infection	1	2
d.	Sepsis	1	2
e.	Infection at SP catheter site	1	2
f.	Other	1🡻	2
	Specify: _____		

B5g. Were there any treatments for any post-op febrile morbidity complications?

Yes..... 1

No..... 2 ➔ **SKIP TO B6**

B5h. Describe any treatments for any post-op febrile morbidity complications: _____

_____

Affix ID Label Here

B6. Were any **pulmonary complications** identified in the post-op period?

Yes..... 1

No..... 2 ➔**SKIP TO B7**

Circle yes or no for all types listed:		***YES***	***NO***
a.	Atelectasis	1	2
b.	Pulmonary edema	1	2
c.	Pneumonia	1	2
d.	Pulmonary embolus	1	2
e.	Aspiration pneumonia	1	2
f.	Laryngospasm	1	2
g.	Other	1🡻	2
	Specify: _____		

B6h. Were there any treatments for any post-op pulmonary complications?

Yes 1

No ..... 2 ➔ **SKIP TO B7**

B6i. Describe any treatments for any post-op pulmonary complications: _____

_____

B7. Were there **any other complications**, of any kind, apparent in the post- op period?

Yes 1

No..... 2 ➔ **SKIP TO B8**

B7a. Describe: _____

_____

B7b. Were there any treatments for any other post-op complications?

Yes 1

No ..... 2 ➔ **SKIP TO B8**

B7c. Describe any treatments for any other post-op complications: _____

_____

Affix ID Label Here

B8. Did the patient receive any **red blood cell transfusion**s during the post-op period?

Yes 1

No..... 2 ➔ **SKIP TO B9**

B8a. Number of **autologous** units: _____ _____ **units**

B8b. Number of **non-autologous** units: _____ _____ **units**

B9. Were there any **surgical complications that required admission to an ICU**?

Yes 1

No..... 2

B10. Did the patient **expire**?

Yes 1

No..... 2

REMINDER: COMPLETE ADVERSE EVENT FORMS & DEATH FORM AS REQUIRED

SECTION C: SURGEON'S SIGNATURE

Surgeon's Signature: _____ Date: ___ ___ / ___ ___ / ___ ___ ___ ___
Month Day Year

Affix ID Label Here

SECTION D: OTHER INFORMATION IN THE IMMEDIATE POST-OPERATIVE PERIOD (PRE-HOSPITAL DISCHARGE)

SECTION D MAY BE COMPLETED BY A UITN CERTIFIED DATA COLLECTOR.

D1. Date of hospital **admission**: ___ ___ / ___ ___ / ___ ___ ___ ___
Month Day Year

D2. Date of **discharge**: ___ ___ / ___ ___ / ___ ___ ___ ___
Month Day Year

D3. Was the patient **discharged with medications** specific to her recovery from the UITN anti-incontinence surgery?

YES 1

NO ..... 2 ➔**SKIP TO D4**

D3a. List medications by name. Include all for which a script was written including controlled and uncontrolled medications:

MEDICATION	**NAME**
1	_____
2	_____
3	_____
4	_____

D4. Had the patient voided prior to discharge? Yes 1

No ..... 2 ➔**SKIP TO D6**

D5. Measured post-void residual volume: _____ _____ _____ **ml**

D5a. How was PVR determined? By fill and flow subtraction method..... 1

By bladder scan / ultrasound 2

By post-void catheterization 3

D6. Specify type of voiding management at discharge:

Urethral catheter..... 1

Supra pubic catheter..... 2

Clean intermittent self-catheterization 3

Self-voiding..... 4

D7. Other UITN Staff *: ___ ___ ___ _____ ___ ___ / ___ ___ / ___ ___ ___ ___
(Initials) (Signature) Month Day Year

* (IF THE SURGEON COMPLETES SECTION D RECORD - 3 IN THE INITIALS FIELD.)