Form 93: Reintervention or Treatment 04/08/03 (B)

Section A: General Study Information for Office Use Only:

A1. Study ID#: LABEL

A2. Visit: RETREATMENT.....RETR

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

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

SECTION B: REINTERVENTION/TREATMENT

B1. Did the patient require treatment for **urge incontinence**?

YES..... 1

NO..... 2 ➔ **SKIP TO B2**

B1a. Circle yes or no for all treatments received by the patient for **urge incontinence**:

		YES	NO
i.	Medication	1	2
ii.	Behavioral or Biofeedback Treatment	1	2
iii.	Other	1	2

a. Specify: _____

B1b. Classify the type of **urge incontinence**:

De novo..... 1

Persistent..... 2 ➔ **SKIP TO B1d**

B1c. What was the date of the first treatment for **de novo urge?** __ __ / __ __ / __ __ __ __ ➔ **SKIP TO B2**
Month Day Year

B1d. Did the patient receive treatment for **persistent urge incontinence** prior to her UITN surgery?

Yes 1

No 2

B1e. What was the date of the first treatment for **persistent urge** following UITN surgery? __ __ / __ __ / __ __ __ __
Month Day Year

Affix ID Label Here

B2. Did the patient require treatment for **retention**?

YES..... 1

NO..... 2 ➔ **SKIP TO B3**

B2a. Circle yes or no for all treatments received by the patient for **retention**:

		YES	NO
i.	Any catheter use new or continuing beyond 6 weeks post-op	1	2
ii.	Sling take-down	1	2
iii.	Suspension take-down	1	2
iv.	Other	1	2

a. Specify: _____

B2b. What was the date of the first treatment for **retention**? ___ ___ / ___ ___ / ___ ___ ___ ___
Month Day Year

B3. Did the patient require treatment for **vaginal prolapse**?

YES..... 1

NO..... 2 ➔ **SKIP TO B4**

B3a. Circle yes or no for all treatments received by the patient for **vaginal prolapse**:

		YES	NO
i.	Anterior repair	1	2
ii.	Posterior repair	1	2
iii.	Enterocele repair	1	2
iv.	Vaginal vault suspension	1	2
v.	Pessary	1	2
vi.	Other	1	2

a. Specify: _____

B3b. What was the date of the first treatment for **vaginal prolapse**? ___ ___ / ___ ___ / ___ ___ ___ ___
Month Day Year

Affix ID Label Here

B4. Did the patient require retreatment for **recurrent stress urinary incontinence (SUI)**?

YES..... 1 ➔ **TREATMENT FAILURE: COMPLETE FAILURE PROTOCOL**

NO..... 2 ➔ **END**

B4a. Circle yes or no for all treatments received by the patient for **recurrent SUI**:

		YES	NO
i.	Burch colposuspension	1	2
ii.	Sling procedure	1	2
iii.	Tightening of previous sling	1	2
iv.	Needle suspension (Raz, Pereyra, Stamey, Gittes, etc.)	1	2
v.	Suburethral plication	1	2
vi.	Collagen injection	1	2
vii.	Other surgical retreatment	1	2
	a. Specify: _____		
viii.	Alpha-agonists	1	2
ix.	Other pharmacologic treatment	1	2
	a. Specify: _____		
x.	Pelvic muscle rehabilitation (with or without biofeedback)	1	2
xi.	Device insertion, such as vaginal cone, pessary, urethral plug, patch	1	2
xii.	Any other treatment	1	2
	a. Specify: _____		

B4b. What was the date of the first retreatment for **recurrent SUI**?

___ ___ / ___ ___ / ___ ___ ___ ___
Month Day Year