Data Collection Sheet (follow-up) – to be completed in consultation with the patient

CONFIDENTIAL

1. **Background Information**

Follow up Number ..... Date of follow-up ..... / ..... / .....

Name ..... Postcode .....

Date of birth ..... / ..... /..... Current Age.....

Mode of follow-up: Face to Face ☐ Telephone ☐

Please insert your practice stamp

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2. **Assessing Symptoms**

How often do you now leak urine? (please circle below)

Never Once a week or less 2-3 times a week once a day several times a day all the time

How much urine do you usually leak? (please circle below)

None a small amount a moderate amount a large amount

Overall, how much does leaking urine now interfere with your everyday life? (please circle a number between 0 (not at all) and 10 (a great deal)

0 1 2 3 4 5 6 7 8 9 10

When does your urine now leak?

- *Never – urine does not leak.....*
- *Leaks before you can go to the toilet.....*
- *Leaks when you cough or sneeze.....*
- *Leaks when you are asleep.....*
- *Leaks when you are physically active / exercising.....*
- *Leaks when you have finished urinating and are dressed.....*
- *Leaks for no obvious reason.....*
- *Leaks all the time.....*

3. **Assessing Improvement**

a) How often have you done your exercises (e.g. daily, twice daily etc.)?.....
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b) How did you remind yourself to do your exercises?
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.....
.....

c) What did you find most helpful in reminding you to exercise?
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d) Was there anything in particular that stopped you from doing your exercises?
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.....
.....

e) Has there been an improvement in your urine leakage following your pelvic floor exercise plan? **Y / N / Not Applicable (if no previous symptoms)**

4. **<u>Modified Oxford Score (if measured at follow-up to be completed by the Practice Nurse)</u>**

Please indicate the grading of the pelvic floor based on the Modified Oxford Scale by circling the appropriate number below:

0 = no contractions **1** = flicker **2** = weak **3** = moderate (with lift) **4** = good (with lift) **5** = strong (with lift)

5. **<u>Follow Up</u>**

Have you recommended this patient for further follow – up? Y/ N

If not, what further action? (i.e. patient refused to participate in exercises, or patient referred to other services.

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6. **Date to follow-up** .....

Mode of follow up preferred: face to face ☐ telephone ☐

(N.B. A face-to-face follow-up may provide an opportunity to measure any change to the MOS score).