Data Collection Sheet (baseline) – to be completed in consultation with the patient.

CONFIDENTIAL

Please insert your practice stamp

1. <u>Background Information</u> **Date** ..... / .... / ......

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

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

Current occupation.....

How many children have you had: **0 1 2 3 4 5+** (please circle as appropriate).

Thinking back to the births, how many were:

- Normal vaginal deliveries.....
- Vaginal deliveries with forceps.....
- Vaginal deliveries with ventouse (suction).....
- Caesarean section.....

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2. <u>Assessing Symptoms</u>

How often do you 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 <u>usually</u> leak? (please circle below)

None a small amount a moderate amount a large amount

Overall, how much does leaking urine 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 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.....*

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3.Modified Oxford Score (to be completed by the practice nurse).

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)

4.Pelvic Floor Muscle Training Plan *(only for those eligible)*

Here the practice nurse should briefly describe the care plan advised to the patient and how often the exercises should be carried out in line with the PERFECT scheme:

Exercise recommended

Intensity.....

Number of Repetitions.....

Number of Fast Contractions.....

5.Follow Up

Have you recommended this patient for 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 (at least 3 months after the start of the exercise programme).....

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

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