ISRCTN71327395 HTA 09/22/136	INVESTIGATE-I INVasive Evaluation before Surgical Treatment for Incontinence: Gives Added Therapeutic Effect?	**Invasive Urodynamic Testing**

Area No	Site No	Participant I.D.	Participant initials

Visit Date: Day / Month / Year

These tests should ONLY be undertaken if patient randomised to 'invasive urodynamic testing' group

TESTS CARRIED OUT

Dual channel cystometry	☐ **Yes** ☐ **No**
Videocystometry	☐ **Yes** ☐ **No**
Ambulatory cystometry	☐ **Yes** ☐ **No**

Time into consulting room/lab	☐☐ HH	☐☐ MM
Time out of consulting room/lab	☐☐ HH	☐☐ MM

Type of operator	☐ Medical	☐ Nursing	☐ Technical
Grade of operator	Specify grade/AfC band:		

TEST DETAILS

Technique	☐ fluid filled catheters	☐ microtip transducers	
Filling position	☐ supine	☐ sitting	☐ standing
Fill rate	☐ 50ml/min	☐ 100ml/min	☐ Other (specify)
Temperature of medium	☐ room temp	☐ body temp	

Completed by:

Name:	Signature:	Invasive urodynamic testing Version 1.0, 27-04-11

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URODYNAMIC VARIABLES

Max free flow rate	☐☐ ml/s	
Voided volume	☐☐☐☐ ml	
Residual volume	☐☐☐☐ ml	
First sensation of filling	☐☐☐ ml	
Max cystometric capacity	☐☐☐☐ ml	
Pressure rise on filling	☐☐☐ cm H2O	
Overactive contractions on filling	☐ Yes	☐ No
Associated with sensation	☐ Yes	☐ No
Associated with leakage	☐ Yes	☐ No
Overactive contractions on provocation	☐ Yes	☐ No
Associated with sensation	☐ Yes	☐ No
Associated with leakage	☐ Yes	☐ No
Urodynamic stress incontinence	☐ Yes	☐ No
Detrusor pressure at max flow (pDetQmax)	☐☐☐ cm H2O	
Maximum flow rate	☐☐ ml/s	
Residual volume	☐☐☐☐ ml	
Max urethral closure pressure	☐☐☐ cm H2O	
Abdominal leak point pressure	☐☐☐ cm H2O	

Completed by:

Name: Signature:

Date ☐☐ Day ☐☐ Month ☐☐☐☐ Year

Area No	Site No	Participant I.D.	Participant initials

URODYNAMIC DIAGNOSIS (tick all that apply)		
Urodynamic stress incontinence	☐ Yes	☐ No
Detrusor overactivity	☐ Yes	☐ No
Increased bladder sensation	☐ Yes	☐ No
Underactive detrusor function	☐ Yes	☐ No
Bladder outflow obstruction	☐ Yes	☐ No
Urethral relaxation incontinence	☐ Yes	☐ No

POST-INVESTIGATION COMPLICATIONS		
Painful micturition	☐ Yes Specify duration:	☐ No
Haematuria	☐ Yes Specify duration:	☐ No
Urinary tract infection	☐ Yes Specify treatment (include medications in medications list)	☐ No
Other (specify):	☐ Yes	☐ No

Completed by:

Name: Signature:

Date (Day / Month / Year)

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TREATMENT PLANNED	
Surgery for SUI/MUI, proposed date:	Day Month Year
Other non-surgical treatment, proposed start date:	Day Month Year

Completed by:		Invasive urodynamic testing
Name:	Signature:	Version 1.0, 27-04-11
Date Day Month Year		