

ISRCTN71327395
HTA 09/22/136



Postoperative follow-up

Area No	Site No	Participant I.D.	Participant initials
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Date of visit	<table border="1" style="margin-left: auto; margin-right: auto;"> <tr> <td style="width: 20%; text-align: center;">Day</td> <td style="width: 20%; text-align: center;">Month</td> <td style="width: 60%; text-align: center;">Year</td> </tr> </table>	Day	Month	Year
Day	Month	Year		

TYPE OF FOLLOW-UP

<input type="checkbox"/> Telephone	<input type="checkbox"/> Questionnaire	<input type="checkbox"/> Clinic	<input type="checkbox"/> None
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ADVERSE EVENTS

If any adverse events were reported since the last visit please record on adverse events pages.
If any serious adverse events were reported since the last visit, notify NCTU immediately.

MEDICATION

If there have been any changes to medication since the last visit please record on the current medications pages.

POSTOPERATIVE FOLLOW-UP

Significant urinary symptoms (patient will be sent symptoms questionnaire at 6 months)	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, specify:
Significant clinical findings	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, specify: <input type="checkbox"/> Tape erosion <input type="checkbox"/> Other
Late postoperative complications:	
Urinary tract infection (requiring treatment from GP or hospital)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Pyrexia (requiring treatment from GP or hospital)	<input type="checkbox"/> Yes <input type="checkbox"/> No

Completed by:	Postoperative follow-up			
Name: _____	Signature: _____			
Date	Version 1.0, 28-04-11			
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POSTOPERATIVE FOLLOW-UP

Severe bruising (requiring treatment by GP or hospital)	<input type="checkbox"/> Yes <input type="checkbox"/> No Specify management:
Wound infection (requiring treatment from GP or hospital)	<input type="checkbox"/> Yes <input type="checkbox"/> No Specify management:
Readmission?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Return to theatre?	<input type="checkbox"/> Yes <input type="checkbox"/> No Specify indication and procedure:

Completed by:		Postoperative follow-up				
Name:	Signature:	Version 1.0, 28-04-11				
Date	<table border="1" style="width: 100%;"> <tr> <td style="width: 25%; text-align: center;">Day</td> <td style="width: 25%; text-align: center;">Month</td> <td style="width: 25%; text-align: center;">Year</td> <td style="width: 25%;"></td> </tr> </table>	Day	Month	Year		
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