ACTIB
Assessing Cognitive
behavioural Therapy
in Irritable Bowel

Note Review Form

Please complete the following form to collect
All consultations 12 m prior to study entry
IBS consultations 12 m prior to study entry
All consultations 12 m post study entry
IBS consultations 12 m post study entry
Any current major medical problems

Study ID

Site

1. Note Review Form Completion Date ddmmyyyy

Patient's Date of Birth ddmmyyyy

Patient Randomisation Date ddmmyyyy

12 months Prior to Recruitment

2. Notes available Yes / No

Patient has left this surgery (tick if yes) ☐ 3b Date if known ddmmyyyy

Patient has died (tick if yes) ☐ Date if known ddmmyyyy

3c. Other reason notes not available

<u>All Consultations</u> 12 months prior to Study Entry

4a. Is there a year of notes available in the 12 months prior to study entry (circle)

Yes / No

4b. Please write the **number** for each type of consultation (not just IBS). Include missed appointments. Do not include immunisations and screening checks.

	Number of Consultations
4c. Nurse	
4d. Doctor	
4e. Phone (doctor or nurse)	
4f. Unknown	

IBS Consultations 12 months prior to Study Entry

Consultation	1	2	3	4
Date of Consultation dd/mm/yyyy	/ /	/ /	/ /	/ /
Nurse (N) Doctor (D) phone (P) unknown (U)	N / D / P / U	N / D / P / U	N / D / P / U	N / D / P / U
Diagnosis or Symptoms (tick all that apply to IBS)				
Diarrhoea	○	○	○	○
Constipation	○	○	○	○
Discomfort/pain anywhere in abdomen	○	○	○	○
More frequent bowel movements	○	○	○	○
Less frequent bowel movements	○	○	○	○
Looser stools (bowel movements)	○	○	○	○
Harder stools (bowel movements)	○	○	○	○
Hard or lumpy stools	○	○	○	○
Loose, mushy or watery stools	○	○	○	○
Abdominal bloating	○	○	○	○

Other diagnoses (only bowel related)	○	○	○	○
Specify diagnosis				
Symptoms				
Treatment given (in relation to IBS or bowel symptoms)	○	○	○	○
Specify drug/dose/duration/unit				
Further Investigations (e.g. TTGA, CRP test)	○	○	○	○
Please specify				
Hospital admission	○	○	○	○
Reason for admission				
Date admission ddmmyyyy	/ /	/ /	/ /	/ /
Date discharge ddmmyyyy	/ /	/ /	/ /	/ /
Specify the speciality, was intensive care used? SAE reported? Y/N				

Referrals	○	○	○	○
Reason for referral (for bowel symptoms only)				
Date referral ddmmyyyy	/ /	/ /	/ /	/ /
Death?	○	○	○	○

12 months Post-Study Entry

Dates

We are interested in the consultations participants have had in the 12 months since entering the study. Please record information for consultations between the following dates inclusive. Please use an extra sheet if there are more than 4 consultations in this time period.

Patient Recruitment Date

12 months After Recruitment

<u>All Consultations</u> 12 months Post-Study Entry

Is there a year of notes available in the 12 months prior to study entry (circle)

Yes/No

Please write the **number** for each type of consultation (not just IBS). Include missed appointments. Do not include immunisations and screening checks.

	Number of Consultations
Nurse	
Doctor	
Phone (doctor or nurse)	
Unknown	

IBS Consultations 12 months Post-Study Entry

Consultation	1	2	3	4
Date of Consultation dd/mm/yyyy	/ /	/ /	/ /	/ /
Nurse (N) Doctor (D) phone (P) unknown (U)	N / D / P / U	N / D / P / U	N / D / P / U	N / D / P / U
Diagnosis or Symptoms (tick all that apply to IBS)				
Diarrhoea	○	○	○	○
Constipation	○	○	○	○
Discomfort/pain anywhere in abdomen	○	○	○	○
More frequent bowel movements	○	○	○	○
Less frequent bowel movements	○	○	○	○
Looser stools (bowel movements)	○	○	○	○
Harder stools (bowel movements)	○	○	○	○
Hard or lumpy stools	○	○	○	○
Loose, mushy or watery stools	○	○	○	○
Abdominal bloating	○	○	○	○

Other diagnoses (only bowel related)	○	○	○	○
Specify diagnosis				
Symptoms				
Treatment given (in relation to IBS or bowel symptoms)	○	○	○	○
Specify drug/dose/duration/unit				
Further Investigations (e.g. TTGA, CRP test)	○	○	○	○
Please specify				
Hospital admission	○	○	○	○
Reason for admission				
Date admission ddmmyyyy	/ /	/ /	/ /	/ /
Date discharge ddmmyyyy	/ /	/ /	/ /	/ /
Specify the speciality, was intensive care used? SAE reported? Y/N				

Referrals	○	○	○	○
Reason for referral (for bowel symptoms only)				
Date referral ddmmyyyy	/ /	/ /	/ /	/ /
Death?	○	○	○	○

Current Major Medical Problems

Please tick any medical problems the patient has currently

Illness	Other descriptions	tick if yes
Heart disease	Ischaemic heart disease (IHD), angina, myocardial infarction, MI, heart attack, atrial fibrillation, atrial flutter, AF, heart block, heart failure, congestive cardiac failure, coronary artery bypass graft or stent, CABG, angioplasty, left ventricular failure (LVF), cardiovascular disease, mitral stenosis or incompetence, aortic stenosis or incompetence, aortic or mitral valve replacement, pacemaker, ventricular dysrhythmia	
Hypertension	High blood pressure	
Respiratory disease	COPD Chronic obstructive pulmonary disease, chronic bronchitis, emphysema	
	Asthma	
	Other lung disease Fibrosis, fibrosing alveolitis, pneumoconiosis, silicosis	
Diabetes	Non insulin dependent (type 2) diabetes, NIDD, insulin dependent diabetes (type 1), IDD	
Thyroid disease	Hypothyroidism, Hyperthyroidism	
Renal/kidney disease	CKD (chronic kidney disease), nephrotic syndrome, nephritis, glomerulo nephritis, kidney/renal transplant	
Musculoskeletal disease	Rheumatoid arthritis **not** osteoarthritis	
	Osteoarthtitis	
Cancer	Hodgkins Lymphoma, non Hodgkins Lymphoma, multiple myeloma, leukaemia, carcinoma, sarcoma	
Stroke/TIA	Cerebro-vascular accident, transient ischaemic attack	

Peripheral vascular disease	Claudication	
Liver disease	Cirrhosis, alcoholic liver disease, non-alcoholic fatty liver disease, NAFLD, hepatitis B, hepatitis C, chronic active hepatitis	
Gastrointestinal disease	Crohn's disease	
	Ulcerative colitis	
	Diverticulitis	
	Dyspepsia, Gastro-Oesophageal Reflux disease (GORD)	
	Coeliac Disease	
	Pancreatic disease	
	Gallbladder disease	
	Other GI disease – (please write here)	
Mental Health	Depression	
	Bipolar Disorder	
	Anxiety, OCD, Panic Disorder	
	Psychosis	
	Eating Disorder	
	Post-traumatic Stress Disorder	
Dementia		
Migraine		

Chronic Fatigue Syndrome	ME	
Fibromyalgia		
Chronic Pelvic Pain syndrome		

Other Major Medical Problems or a Query

(a term that may indicate one of these illnesses)