# Regional Stress Urinary Incontinence MDM

[INSERT NAME OF REGION HERE]

Please complete electronically, no handwritten referrals will be accepted. Email to xxx@yyyy.org.nz

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| **MDM Referral**(Filled in by referring practitioner) |

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| **Patient and Referrer details** |
| Patient Name |
| DOBAge | NHI | Recorded Ethnicity  | BMI | ACC accepted claim for Maternal Birth Injury 🞎 Yes 🞎 No |
| Referring Clinician Name | Referring Hospital | Referrer email |
| Reason for referral: Are you considering SUI surgery on your patient? 🞎 Yes 🞎 No If **Yes** – case must be presented at MDM🞎 recurrent incontinence 🞎 Discuss complex case  |
| Preferred date of MDM dd/mm/yyyy | Does this case reach the Manatū Hauora’s criteria for SUI* Exception for surgical mesh 🞎 Yes 🞎 No
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| **Patient History** |
| Presenting complaint (including severity of symptoms) | Stress 🞎 Yes 🞎 No Urge or urge incontinence 🞎 Yes 🞎 No Nocturnal enuresis 🞎 Yes 🞎 No Flooding incontinence 🞎 Yes 🞎 No **Severity:** Degree of bother (free text) Pads used/day (box to enter number)Number of episodes (free text option) |
| Screening for non-index features  | Presence of voiding dysfunction (slow flow/ hesitancy etc)  | 🞎Yes 🞎 no |
| Presence of complex features (haematuria, pelvic radiotherapy, neurological disease, recurrent UTI, radical pelvic surgery)  | 🞎Yes 🞎 no |
| Diagnosis |  |
| Effects on QoL |  |
| Patient goals of treatment |  |
| Previous pelvic surgery | 🞎 Yes🞎 No  | If yes:Incontinence surgery 🞎 Yes 🞎 No  | If yes; what type 🞎 mesh 🞎 sling 🞎 fascia 🞎 Burch 🞎bulking 🞎 other Specify other\_\_\_\_\_\_\_\_\_\_\_\_ | Prolapse surgery 🞎 Yes 🞎 No If yes specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Significant/relevant surgical history | 🞎 Yes 🞎 No If yes -specify |
| Significant/ relevant medical history | 🞎 Yes 🞎 No If yes, select as many as required🞎 diabetes 🞎 neurological disease/event 🞎pelvic radiotherapy 🞎 chemotherapy 🞎 MI 🞎 other |
| Parity(free text box) | Future fertility desired 🞎 Yes 🞎 No | Patient has been informed of MDM discussion and process.🞎 Yes 🞎 No | PROMs captured 🞎 Yes 🞎 NoResponses\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Sexual functionSexually active🞎 Yes 🞎 No | If No, is this due to (select as many as indicated) 🞎 pain 🞎 obstruction 🞎 incontinence 🞎 not due to gynaecological issues 🞎 no partner 🞎 not planning on becoming SA |
| Pain (describe)🞎 Yes 🞎 NoIf yes tick as many boxes as indicated🞎 Dyspareunia 🞎 Chronic pelvic pain endo/adenomyosis 🞎 CRPS 🞎 Rheumatology type pain 🞎 Bladder pain🞎 other – specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Prolapse Symptomsvaginal bulge symptoms only 🞎 Yes 🞎 No | Significant/relevant bowel symptoms 🞎 Yes 🞎 NoBowel exam 🞎 Yes 🞎 No Findings:\_\_\_\_\_\_\_\_\_\_\_\_Free text what is relevant to this diagnosis\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **Examination findings**  | General | Urine stress testUrethral hypermobility: 🞎 Yes 🞎 No |
| Bimanual exam🞎Normal 🞎 Abnormal 🞎 Not done Reasons for not completed.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Pelvic floor Pain 🞎 Yes 🞎 No 🞎 not assessedStrength (use modified Oxford grading) 🞎 no contraction 🄋🞎 Flicker ➀ 🞎 Weak ➁🞎 Moderate➂ 🞎 Good ➃ 🞎strong ➄ |
| Uroflow/PVR | MSU result normal/ abnormal | Mesh exposure 🞎 Yes 🞎 NoPain over mesh 🞎 Yes 🞎 No |
|  POP-Q (optional)<https://www.augs.org/patient-services/pop-q-tool/> Click on link to tool – enter scores here.

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| Aa | Ba | C |
| gh | pb | tvl |
| Ap | Bp | D |

 | Other (Mandatory)POP-Q Grade (enter score) Anterior:Apical:Posterior: |
| **Urodynamics** | Date performed & location | Bladder Diary 🞎 Yes 🞎 No |
| Free Flow/PVR | First sensation |
| Bladder Capacity | DO Yes/no  |
| SUI – LPP(cmH20) | VoidingQmax Pdet@Qmax |
| Optional* Comment on detrusor contraction
* BOOif
* BCI
* Tracing attached for review 🞎 Yes 🞎 No
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| **Radiology Findings** | Date  | Location | Modality | Finding |
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| **Non-surgical management to date** | Supervised pelvic floor training.🞎 Yes 🞎 No Date completed dd/mm/yyyy | Continence Pessary offered/trialled.🞎 Yes 🞎 No  | Relevant medications trialled.  |
| **Written information on treatment options given to patient.**  | Name MH document here[[1]](#footnote-1)🞎 Yes 🞎 No |  Other – name Propose drop down option for NZ PDA, etc. and “other: option allowing type in for literature options |
| **Surgical options discussed with patient**  | List surgical options discussed with patient (tick all that apply).* Mesh 🞎 Yes 🞎 No
* Fascial sling 🞎 Yes 🞎 No
* Burch Colposuspension 🞎 Yes 🞎 No
* Urethral bulking 🞎 Yes 🞎 No

If **NO** to any of above enter reason enter rationale why it has not been offered, including clinical reasons if not suitable. | Patient preference for treatment options discussed:**Tick all that apply**🞎 Mesh🞎 Fascial 🞎 Burch Colposuspension🞎 Urethral bulking 🞎 Other - (free text)  |
| **Referring clinician recommend surgery type** | 🞎 Mesh 🞎 Fascial🞎 Burch colposuspension🞎 Urethral bulking 🞎 Other – please type  | **Rational for referring surgeon recommendation****Note:** *Index = standard, clear diagnosis without UDS v's non-index where diagnosis is not so clear cut* |

# MDM Outcome Form

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| **MDM Discussion** |
| Date | Chair |
| Attendees’ designation and name |
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| Quorum achieved 🞎 Yes 🞎 NoPresent: 🞎 2 SMO ideally from 2 different centre who meet ToR criteria 🞎 CNS - Continence) 🞎 Pelvic health physiotherapist 🞎 Radiology (quorum for specified cases only) |

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| **MDT Recommendations** |
| Additional investigations recommend |  |
| Additional non-surgical treatment recommended |  |
| Surgery considered appropriate | 🞎 Yes 🞎 No |
| Type of surgery recommended |  |
| Rationale for treatment recommendation |  |
| Will this treatment option help achieve the patients’ goals for treatment | 🞎 Yes 🞎 No |
| Suggested place of surgery |  |
| Follow up plan |  |
| Other MDT recommendations |  |
| Place holder row for information required to send to the national registry provider | No action required |

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| **High Vigilance Monitoring** |
| Does the patient meet the High Vigilance criteria | 🞎 Yes 🞎 No |
| Have pelvic floor muscle exercises been trialled | 🞎 Yes 🞎 No |
| Have urodynamics been performed and interpreted by an appropriately trained clinician | 🞎 Yes 🞎 No |
| Has the patient been through a shared decision-making  | 🞎 Yes 🞎 No |
| Has the patient been through an informed consent process including the use of a patient decision aid? | 🞎 Yes 🞎 No |
| Has the patient been offered treatment that would benefit the patient but is not offered by the referring clinician | 🞎 Yes 🞎 No |
| Is the surgeon credentialed to perform the recommended surgery | 🞎 Yes 🞎 No |
| Is a follow up plan documented | 🞎 Yes 🞎 No |
| Does the patient reach the threshold for escalation to the Mesh Exceptions group | 🞎 Yes 🞎 No |
| Name of person recording outcome of discussion |  |

1. Insert link to MH SUI patient information site [↑](#footnote-ref-1)