Patient Name: _____

Patient ID#: _____

Patient DOB: _____

(or affix Patient Label)

Percutaneous Tibial Nerve Stimulation with Urgent® PC

Onset of symptoms: ____/____/_____

Diagnosis: urgency frequency urge incontinence OAB

ICD-10 Code: R39.15 R35.0 N39.41 N32.81

Previous treatment	Why stopped	Duration/Dates
Behavior Modification		
Biofeedback		
E-Stim		
Drug 1: _____		
Drug 2: _____		
Other: _____		

Clinic Information

Session	Date	Initials	Medical Review									PTNS Treatment		
			Patient goals and Progress	Related Health & Social Factors	Caffeine #/day	Alcohol #/day	Daytime Voids #/day	Night-time Voids #/night	Urgency 0 = none, 4 = severe	Incontinence Episodes #/day	Treatment Plan/ Comments	Ankle Used	Treatment Setting	Feeling/ Response
1			□ ↓ urgency □ ↓ frequency □ no accidents □ Sleep through night □ Void every ____ hours □ No leaks during intercourse □ _____								□ ↑/↓fluids □ ↓ Caffeine □ Urge reduction techniques □ Kegels □ Toilet every ___ hours □ No fluids before bed □ _____	R L		□ Toe Flex □ Foot Sensation □ Both
2				□ Same □ Change								R L		□ Toe Flex □ Foot Sensation □ Both
3				□ Same □ Change								R L		□ Toe Flex □ Foot Sensation □ Both

Clinician Name _____ Initials: _____ Clinician Signature: _____ Initials _____

Session	Date	Initials	Medical Review									PTNS Treatment		
			Patient goals and Progress	Related Health & Social Factors	Caffeine #/day	Alcohol #/day	Daytime Voids #/day	Night-time Voids #/night	Urgency 0 = none, 4 = severe	Incontinence Episodes #/day	Treatment Plan/ Comments	Ankle Used	Treatment Setting	Feeling/ Response
4				□ Same □ Change								R L		□ Toe Flex □ Foot Sensation □ Both
5				□ Same □ Change								R L		□ Toe Flex □ Foot Sensation □ Both
6			□ ↓ urgency □ ↓ frequency □ no accidents □ Sleep through night □ Void every ____ hours □ No leaks during intercourse □ _____	□ Same □ Change							□ ↑/↓fluids □ ↓ Caffeine □ Urge reduction techniques □ Kegels □ Toilet every ___ hours □ No fluids before bed □ _____	R L		□ Toe Flex □ Foot Sensation □ Both
7				□ Same □ Change								R L		□ Toe Flex □ Foot Sensation □ Both
8				□ Same □ Change								R L		□ Toe Flex □ Foot Sensation □ Both

Clinician Name _____ Initials: _____ Clinician Signature: _____ Initials _____

Session	Date	Initials	Medical Review									PTNS Treatment		
			Patient goals and Progress	Related Health & Social Factors	Caffeine #/day	Alcohol #/day	Daytime Voids #/day	Night-time Voids #/night	Urgency 0 = none, 4 = severe	Incontinence Episodes #/day	Treatment Plan/ Comments	Ankle Used	Treatment Setting	Feeling/ Response
9				□ Same □ Change								R L		□ Toe Flex □ Foot Sensation □ Both
10				□ Same □ Change								R L		□ Toe Flex □ Foot Sensation □ Both
11				□ Same □ Change								R L		□ Toe Flex □ Foot Sensation □ Both
12			□ ↓ urgency □ ↓ frequency □ no accidents □ Sleep through night □ Void every ____ hours □ No leaks during intercourse □ _____	□ Same □ Change							□ ↑/↓fluids □ ↓ Caffeine □ Urge reduction techniques □ Kegels □ Toilet every ___ hours □ No fluids before bed □ _____ □ Next treatment in____ days	R L		□ Toe Flex □ Foot Sensation □ Both
12 Week Review														

Clinician Name _____ Initials: _____ Clinician Signature: _____ Initials _____

Session	Date	Initials	Medical Review									PTNS Treatment		
			Patient goals and Progress	Related Health & Social Factors	Caffeine #/day	Alcohol #/day	Daytime Voids #/day	Night-time Voids #/night	Urgency 0 = none, 4 = severe	Incontinence Episodes #/day	Treatment Plan/ Comments	Ankle Used	Treatment Setting	Feeling/ Response
				☐ Same ☐ Change							☐ ↑/↓fluids ☐ ↓ Caffeine ☐ Urge reduction techniques ☐ Kegels ☐ Toilet every ___ hours ☐ No fluids before bed ☐ ____________________ ☐ Next treatment in ___ days	R L		☐ Toe Flex ☐ Foot Sensation ☐ Both
				☐ Same ☐ Change							☐ ↑/↓fluids ☐ ↓ Caffeine ☐ Urge reduction techniques ☐ Kegels ☐ Toilet every ___ hours ☐ No fluids before bed ☐ ____________________ ☐ Next treatment in ___ days	R L		☐ Toe Flex ☐ Foot Sensation ☐ Both
				☐ Same ☐ Change							☐ ↑/↓fluids ☐ ↓ Caffeine ☐ Urge reduction techniques ☐ Kegels ☐ Toilet every ___ hours ☐ No fluids before bed ☐ ____________________ ☐ Next treatment in ___ days	R L		☐ Toe Flex ☐ Foot Sensation ☐ Both
				☐ Same ☐ Change							☐ ↑/↓fluids ☐ ↓ Caffeine ☐ Urge reduction techniques ☐ Kegels ☐ Toilet every ___ hours ☐ No fluids before bed ☐ ____________________ ☐ Next treatment in ____days	R L		☐ Toe Flex ☐ Foot Sensation ☐ Both

Clinician Name ______________________________________ Initials: ______ Clinician Signature: ____ Initials ______