Queensland Government

Metro South Health

Colorectal Pelvic Floor Clinic

FAECAL INCONTINENCE - QUALITY OF LIFE SCORING SHEET

Facility: QEII JUBILEE HOSPITAL

(Affix patient identification label here)

URN:

Family Name:

Given Names:

Date of Birth: Sex: ☐M ☐F ☐I

Date:_____

Scales range from 1 to 4; with a 1 indicating a lower functional status of quality of life. Scales scores are the average (mean) response to all items in the scale (e.g. add the responses to all questions in a scale together and then divide by the number of items in the scale N.B. adjust for missing values). (Not apply is coded as a missing value in the analysis for all questions).

Scale 1. Lifestyle, ten items.

	Q2A	Q2B	Q2C	Q2D	Q2E	Q2G	Q2H	Q3B	Q3L	Q3M	
Response:	___	___	___	___	___	___	___	___	___	___	___/10 =___

Scale 2. Coping/Behaviour, nine items.

	Q2F	Q2I	Q2J	Q2K	Q2M	Q3C	Q3H	Q3J	Q3N	
Response:	___	___	___	___	___	___	___	___	___	___/9 =___

Scale 3. Depression/Self Perception, seven items.

	Q1	Q3D	Q3F	Q3G	Q3I	Q3K	Q4	
Response:	___	___	___	___	___	___	___	___/7 =___

Scale 4. Embarrassment, three items.

	Q2L	Q3A	Q3E	
Response:	___	___	___	___/3 =___

Nurse's Name:_____

Nurse's Signature:_____

Ref: Adapted from Rockwood TH, Church JM, Fleshman JW, Kane RL, Mavrantonis C, Thorson AG, Wexner SD, Bliss D, Lowry AC (2000).

DO NOT WRITE IN THIS BINDING MARGIN

FAECAL INCONTINENCE - QUALITY OF LIFE SCORING SHEET

Queensland Government

Metro South Health

Colorectal Pelvic Floor Clinic

FAECAL INCONTINENCE - QUALITY OF LIFE SCORE

Facility: QEII JUBILEE HOSPITAL

(Affix patient identification label here)

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Family Name:

Given Names:

Date of Birth: Sex: ☐M ☐F ☐I

Date:_____

Q1. In general, would you say your health is:	Excellent 5	Very Good 4	Good 3	Fair 2	Poor 1
	☐	☐	☐	☐	☐

Q2. For each of the items, please indicate how much of the time the issue is a concern for you:	Most of the time 1	Some of the time 2	A little of the time 3	None of the time 4
Due to accidental bowel leakage:				
a. I am afraid to go out	☐	☐	☐	☐
b. I avoid visiting friends	☐	☐	☐	☐
c. I avoid staying overnight away from home	☐	☐	☐	☐
d. It is difficult for me to get out and do things like going to a movie or to church	☐	☐	☐	☐
e. I cut down on how much I eat before I go	☐	☐	☐	☐
f. Whenever I am away from home, I try to stay near a restroom as much as possible	☐	☐	☐	☐
g. It is important to plan my schedule (daily activities) around my bowel pattern	☐	☐	☐	☐
h. I avoid travelling	☐	☐	☐	☐
i. I worry about not being able to get to the toilet in time	☐	☐	☐	☐
j. I feel I have no control over my bowels	☐	☐	☐	☐
k. I can't hold my bowel movement long enough to get to the bathroom	☐	☐	☐	☐
l. I leak stool without even knowing it	☐	☐	☐	☐
m. I try to prevent bowel accidents by staying very near a bathroom	☐	☐	☐	☐

Q3. Please indicate the extent to which you **agree or disagree** with each of the following:	Strongly agree 1	Somewhat agree 2	Somewhat disagree 3	Strongly disagree 4
Due to accidental bowel leakage:				
a. I feel ashamed	☐	☐	☐	☐
b. I cannot do many of things I want to do	☐	☐	☐	☐
c. I worry about bowel accidents	☐	☐	☐	☐
d. I feel depressed	☐	☐	☐	☐
e. I worry about others smelling stool on me	☐	☐	☐	☐
f. I feel like I am not a healthy person	☐	☐	☐	☐
g. I enjoy life less	☐	☐	☐	☐
h. I have sex less often than I would like to	☐	☐	☐	☐
i. I feel different from other people	☐	☐	☐	☐
j. The possibility of bowel accidents is always on my mind	☐	☐	☐	☐

DO NOT WRITE IN THIS BINDING MARGIN

FAECAL INCONTINENCE - QUALITY OF LIFE SCORE

Queensland Government

Metro South Health

Colorectal Pelvic Floor Clinic

FAECAL INCONTINENCE - QUALITY OF LIFE SCORE

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Given Names:

Date of Birth: Sex: ☐M ☐F ☐I

	Strongly agree	Somewhat agree	Somewhat disagree	Strongly disagree
	1	2	3	4
k. I am afraid to have sex	☐	☐	☐	☐
l. I avoid travelling by plane or train	☐	☐	☐	☐
m. I avoid going out to eat	☐	☐	☐	☐
n. Whenever I go to somewhere new, I specifically locate where the bathrooms are	☐	☐	☐	☐

Q4. During the past month, have you felt so sad, discouraged, hopeless or had so many problems that you wondered if any thing was worthwhile?	Extremely so	Very much so	Quite a bit	Some-Enough to bother me	A little bit	Not at all
	1	2	3	4	5	6
	☐	☐	☐	☐	☐	☐

Thank you

Ref: Adapted from Rockwood TH, Church JM, Fleshman JW, Kane RL, Mavrantonis C, Thorson AG, Wexner SD, Bliss D, Lowry AC (2000).

FAECAL INCONTINENCE - QUALITY OF LIFE SCORE

DO NOT WRITE IN THIS BINDING MARGIN

Queensland Government

Metro South Health

Colorectal Pelvic Floor Clinic

FISI/VAIZEY/WEXNER SCORE

Facility: QEII JUBILEE HOSPITAL

(Affix patient identification label here)

URN:

Family Name:

Given Names:

Date of Birth: Sex: ☐M ☐F ☐I

Date_____

Score: FISI:_____ /24 VAIZEY:_____ /24 WEXNER:_____ /20

(Lower score = increased severity of symptoms)

FISI (Faecal Incontinence Severity Index)

For each of the following, please indicate on average **how often in the past month** you experienced any amount of accidental bowel leakage

	2 or more times a day	Once a day	2 or more times a week	Once a week	1 to 3 times a month	Never
	1	2	3	4	5	6
Gas	☐	☐	☐	☐	☐	☐
Mucus	☐	☐	☐	☐	☐	☐
Liquid stool	☐	☐	☐	☐	☐	☐
Solid stool	☐	☐	☐	☐	☐	☐

Ref: Adapted from Rockwood TH, Church JM, Fleshman JW, Kane RL, Mavrantonis C, Thorson AG, Wexner SD, Bliss D, Lowry AC (1999).

St Mark's Incontinence Score (Vaizey)

In the last **four weeks** did you:

	Never (No episodes) 0	**Rarely** (One episode) 1	**Sometimes** (More than one episode but less than one per week) 2	**Weekly** (One or more episodes per week but less than one per day) 3	**Daily** (One or more episodes per day) 4
Suffer from incontinence of solid stool	☐	☐	☐	☐	☐
Suffer from incontinence of liquid stool	☐	☐	☐	☐	☐
Suffer from incontinence of gas	☐	☐	☐	☐	☐
Have an alteration in lifestyle/ Not do something you would have liked to do	☐	☐	☐	☐	☐

	No 0	**Yes** 2
Need to wear a pad or plug	☐	☐
Take constipating medications	☐	☐

	No 0	**Yes** 4
Lack the ability to defer passing stool for 15 minutes	☐	☐

Ref: Adapted from Vaizey CJ, Carapeti E, Cahill JA, Kamm MA (1999).

Please turn over

DO NOT WRITE IN THIS BINDING MARGIN

FISI / VAIZEY / WEXNER SCORE SHEET

Queensland Government

Metro South Health

Colorectal Pelvic Floor Clinic

FISI/VAIZEY/WEXNER SCORE

Facility: QEII JUBILEE HOSPITAL

(Affix patient identification label here)

URN:

Family Name:

Given Names:

Date of Birth: Sex: ☐M ☐F ☐I

Wexner Continence Grading Scale

Please tick the most appropriate box for each question.

Do you:

	Never (No episodes) 0	**Rarely** (Less than once per month) 1	**Sometimes** (Less than once per week but more than once per month) 2	**Usually** (Less than once per day but more than once per week) 3	**Always** (More than once per day) 4
Suffer from incontinence of solid stool	☐	☐	☐	☐	☐
Suffer from incontinence of liquid stool	☐	☐	☐	☐	☐
Suffer from incontinence of gas (wind)	☐	☐	☐	☐	☐
Need to wear a pad or plug	☐	☐	☐	☐	☐
Have an alteration in lifestyle/ Not do something you would have liked to do	☐	☐	☐	☐	☐

Ref: Adapted from Jorge JMN, Wexner SD (1993).

Queensland Government
Metro South Health
Colorectal Pelvic Floor Clinic

PATIENT ASSESSMENT OF CONSTIPATION - QUALITY OF LIFE SCORING SHEET

Facility: QEII JUBILEE HOSPITAL

(Affix patient identification label here)

URN:

Family Name:

Given Names:

Date of Birth: Sex: ☐M ☐F ☐I

Date: _____

Scales 1 - 3 are used to assess the patient dissatisfaction index with an overall score of 0 - 96 where lower scores correspond to better quality of life. The satisfaction sub-scale (4) ranges from 0 - 16 with the patient's outcome defined as poor (0 - 4), fairly good (5 - 8), good (9 - 12) or excellent (13 - 16).

Scale 1. **Physical discomfort** (questions 1 - 4)

	Q1	Q2	Q3	Q4	
Response:	___	___	___	___	Score: ___ /16

Scale 2. **Psychosocial discomfort** (questions 5 - 12)

	Q5	Q6	Q7	Q8	Q9	Q10	Q11	Q12	
Response:	___	___	___	___	___	___	___	___	Score: ___ /32

Scale 3. **Worries/concerns** (questions 13 - 23)

	Q13	Q14	Q15	Q16	Q17	Q18	Q19	Q20	Q21	Q22	Q23	Q24	
Response:	___	___	___	___	___	___	___	___	___	___	___	___	Score: ___ /48

Dissatisfaction Overal Score:___ /96

Scale 4. **Satisfaction** (questions 24 - 28)

	Q25	Q26	Q27	Q28	
Response:	___	___	___	___	**Satisfaction Overal Score:___ /16**

Nurse's Name: _____

Nurse's Signature: _____

DO NOT WRITE IN THIS BINDING MARGIN

PATIENT ASSESSMENT OF CONSTIPATION - QUALITY OF LIFE SCORING SHEET

Queensland Government

Metro South Health

Colorectal Pelvic Floor Clinic

CONSTIPATION SCORING SYSTEM

Facility: QEII JUBILEE HOSPITAL

(Affix patient identification label here)

URN:

Family Name:

Given Names:

Date of Birth: Sex: ☐M ☐F ☐I

Date:_____ **Score:**_____/30

Please tick the answer that best fits your current experience/symptoms. (Tick one only for each question)

	1 to 2 times per 1 to 2 days	2 times per week	Once per week	Less than once per week	Less than once per month
	0	1	2	3	4
What is the frequency of your bowel movement	☐	☐	☐	☐	☐
	Never	Rarely	Sometimes	Usually	Always
	0	1	2	3	4
Is passing of stools painful	☐	☐	☐	☐	☐
	Never	Rarely	Sometimes	Usually	Always
	0	1	2	3	4
Do you feel you have incompletely passed the stool	☐	☐	☐	☐	☐
	Never	Rarely	Sometimes	Usually	Always
	0	1	2	3	4
Do you have abdominal pain	☐	☐	☐	☐	☐
	Less than 5 minutes	5 to 10	10 to 20	20 to 30	More than 30
	0	1	2	3	4
How long at one visit do you spend trying to pass stool	☐	☐	☐	☐	☐
	Without assistance	Stimulative laxatives	Finger assisted or enema		
	0	1	2		
Do you need any type of assistance with passing stools	☐	☐	☐		
	Never	1 to 3	3 to 6	6 to 9	More than 9
	0	1	2	3	4
How many unsuccessful attempts to pass stool do you have per day	☐	☐	☐	☐	☐
	0	1 to 5	5 to 10	10 to 20	More than 20
	0	1	2	3	4
How long have you been experiencing constipation (in years)	☐	☐	☐	☐	☐

Ref: Adapted from Agachan F, Chen T, Pfeifer J, Reissmon P, Wexner SD (1996).

Thank you

DO NOT WRITE IN THIS BINDING MARGIN

CONSTIPATION SCORING SYSTEM

Queensland Government

Metro South Health

Colorectal Pelvic Floor Clinic

OBSTRUCTED DEFAECATION SCORE (ODS)

Facility: QEII JUBILEE HOSPITAL

(Affix patient identification label here)

URN:

Family Name:

Given Names:

Date of Birth: Sex: ☐M ☐F ☐I

Date:_____ **Score:**_____**/31**

Please tick the answer that best fits your current experience/symptoms. (Tick one only for each question)

	Less than or equal to 5 minutes (0)	6 to 10 minutes (1)	11 to 20 minutes (2)	21 to 30 minutes (3)	Greater than 30 minutes (4)
1) What is the average amount of time you spend at the toilet	☐	☐	☐	☐	☐

	One (0)	Two (1)	Three to four (2)	Five to six (3)	Greater than 6 (4)
2) How many attempts to pass stool do you make per day	☐	☐	☐	☐	☐

	Never (0)	Greater than 1 per month but less than 1 per week (1)	Once per week (2)	2 to 3 per week (3)	Every time (4)
3) How often do you use your fingers (anal/vaginal) to assist in passing stools	☐	☐	☐	☐	☐
4) How often do you have incomplete/ fragmented passage of stools	☐	☐	☐	☐	☐
5) How often do you use laxatives	☐	☐	☐	☐	☐
6) How often do you use enemas	☐	☐	☐	☐	☐

Page Turn Over

OBSTRUCTED DEFAECATION SCORE (ODS)

Queensland Government

Metro South Health

Colorectal Pelvic Floor Clinic

OBSTRUCTED DEFAECATION SCORE (ODS)

Facility: QEII JUBILEE HOSPITAL

(Affix patient identification label here)

URN:

Family Name:

Given Names:

Date of Birth: Sex: ☐M ☐F ☐I

	Never	Less than 25% of the time	Less than 50% of the time	Less than 75% of the time	Every time
	0	1	2	3	4
7) How often do you strain when passing stools	☐	☐	☐	☐	☐

	Soft	Hard	Hard and few	Faecaloma formation (very hard, like stone)
	0	1	2	3
8) On average, what is the consistency of your stools	☐	☐	☐	☐

Ref: Adapted from Altomare DF, Spazzafumo L, Rinaldi M, Dodi G, Ghiselli R, Piloni V

Thank you

OBSTRUCTED DEFAECATION SCORE (ODS)

DO NOT WRITE IN THIS BINDING MARGIN

Queensland Government

Metro South Health

Colorectal Pelvic Floor Clinic

PATIENT ASSESSMENT OF CONSTIPATION - QUALITY OF LIFE SCORE

Facility: QEII JUBILEE HOSPITAL

(Affix patient identification label here)

URN:

Family Name:

Given Names:

Date of Birth: Sex: ☐M ☐F ☐I

Date:_____

The following questions are designed to measure the impact constipation has had on your daily life during **the past 2 weeks**. For each question, please tick one box.

The following questions ask you about the intensity of your symptoms of constipation. During the past 2 weeks, to what extent have you:

	Not at all 0	A little bit 1	Moderately 2	Quite a bit 3	Extremely 4
1. Felt bloated to the point of bursting?	☐	☐	☐	☐	☐
2. Felt heavy because of your constipation?	☐	☐	☐	☐	☐

The next few questions ask you about the effects of constipation on your daily life. During the past 2 weeks, how much of the time have you:

	None of the time 0	A little of the time 1	Some of the time 2	Most of the time 3	All of the time 4
3. Felt any physical discomfort?	☐	☐	☐	☐	☐
4. Felt the need to open your bowel but not been able to?	☐	☐	☐	☐	☐
5. Been embarrassed to be with other people?	☐	☐	☐	☐	☐
6. Been eating less and less because of not being able to have bowel movements?	☐	☐	☐	☐	☐

The next few questions ask you about the effects of constipation on your daily life. To what extent during the past 2 weeks, have you:

	Not at all 0	A little bit 1	Moderately 2	Quite a bit 3	Extremely 4
7. Had to be careful about what you eat?	☐	☐	☐	☐	☐
8. Had a decreased appetite?	☐	☐	☐	☐	☐
9. Been worried about not being able to choose what you eat (e.g. at a friend's house)	☐	☐	☐	☐	☐
10. Been embarrassed about staying in the toilet for so long when you were away from home?	☐	☐	☐	☐	☐
11. Been embarrassed about having to go to the toilet so often when you were away from home?	☐	☐	☐	☐	☐
12. Been worried about having to change your daily routine (for example, travelling, being away from home)?	☐	☐	☐	☐	☐

Please turn over

DO NOT WRITE IN THIS BINDING MARGIN

PATIENT ASSESSMENT OF CONSTIPATION - QUALITY OF LIFE SCORE

Queensland Government

Metro South Health

Colorectal Pelvic Floor Clinic

PATIENT ASSESSMENT OF CONSTIPATION - QUALITY OF LIFE SCALE

Facility: QEII JUBILEE HOSPITAL

(Affix patient identification label here)

URN:

Family Name:

Given Names:

Date of Birth: Sex: ☐M ☐F ☐I

The next few questions ask you about your feelings. How much of the time, during the past 2 weeks have you:

	None of the time 0	A little of the time 1	Some of the time 2	Most of the time 3	All of the time 4
13. Felt irritable because of your condition?	☐	☐	☐	☐	☐
14. Been upset by your condition?	☐	☐	☐	☐	☐
15. Felt obsessed by your condition?	☐	☐	☐	☐	☐
16. Felt stressed by your condition?	☐	☐	☐	☐	☐
17. Been less self-confident because of your condition?	☐	☐	☐	☐	☐
18. Not felt in control of your condition?	☐	☐	☐	☐	☐

The next questions ask you about your feelings. To what extent, during the past 2 weeks have you:

	Not at all 0	A little bit 1	Moderately 2	Quite a bit 3	Extremely 4
19. Been worried about not knowing when you are going to be able to open your bowels?	☐	☐	☐	☐	☐
20. Been worried about not being able to open your bowels when you needed to?	☐	☐	☐	☐	☐
21. Been more and more bothered by not being able to open your bowels?	☐	☐	☐	☐	☐

The next few questions ask about your life with constipation. How much of the time during the past 2 weeks have you:

	None of the time 0	A little of the time 1	Some of the time 2	Most of the time 3	All of the time 4
22. Been afraid that your condition will get worse	☐	☐	☐	☐	☐
23. Felt that your body was not working properly?	☐	☐	☐	☐	☐
24. Had fewer bowel movements than you would like?	☐	☐	☐	☐	☐

The next questions ask you about how satisfied you are. To what extent during the past 2 weeks have you been:

	Not at all 0	A little bit 1	Moderately 2	Quite a bit 3	Extremely 4
25. Satisfied with how often you open your bowels?	☐	☐	☐	☐	☐
26. Satisfied with the regularity with which you open your bowels?	☐	☐	☐	☐	☐
27. Satisfied with your bowel function?	☐	☐	☐	☐	☐
28. Satisfied with your treatment?	☐	☐	☐	☐	☐

Ref: Adapted from Marquis P, De La Loge C, Dubois D, McDermott A, Chassany O (2005).

Thank you

PATIENT ASSESSMENT OF CONSTIPATION - QUALITY OF LIFE SCALE

DO NOT WRITE IN THIS BINDING MARGIN