Fecal Incontinence Device
Multicentre study protocol

Name of supervising doctor: ***Hospital:***

Contact e-mail address:

Contact telephone number:

Name of patient: ………………………………………………………

Date of birth: ………………………………………………………

Contact telephone number: ………………………………………………………

Contact e-mail address ………………………………………………………

Original pathology: ………………………………………………………

Operations performed: ………………………………………………………

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Investigations performed :

Contrast enema ………………………………………………………

Electromyogram ………………………………………………………

Others ………………………………………………………

- **Sensation at anal region:** normal Weak absent
- **Starting Date of using the device:**
- **No. of days needed for adaptation:**
- **Amount of water (air) needed in the balloon**
- **Do you use the device at night?**
- **Do use washout?** **How often?**
- **How often do you use the device?**
- **Complications following the use of device** ………………………………………

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Suggestions : ………………………………………………………

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