

MUSIC Follow-Up Visit

VISIT DATE

Visit Date: □□-□□□□-□□□□
(DD-MMM-YYYY)

Visit Timepoint: ☐ 3 months ☐ 6 months ☐ 9 months ☐ 12 months

PATIENT DETAILS

CHI No. □□□□□□□□□□

CLINICAL ASSESSMENT

Weight: □□□.□ kg

Current smoking status: ☐ Yes ☐ No ☐ Ex -smoker If ex-smoker, when did they stop? _____

Current active IBD symptoms: ☐ Yes ☐ No

Description of symptoms:

Physician's Global Assessment: ☐ Remission ☐ Mildly active ☐ Moderately active ☐ Severely active

Comments:

CLINICAL ASSESSMENT – CROHN'S DISEASE

HBI – circle relevant options below

Total = sums of items on table + number of liquid stool/day

<5 remission, 5-7 mild, 8-16 moderate, >16 severe

	0	1	2	3	4
Wellbeing	Very well	Slightly below par	Poor	Very Poor	Terrible
Abdo pain	None	Mild	Moderate	Severe	
Abdo mass	Nil	Dubious	Definite	Definite and tenderness	
Arthralgia	No	Yes			
Uveitis	No	Yes			
Erythema nodosum	No	Yes			
Aphthous ulcers	No	Yes			

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Pyoderma gangrenosum	No	Yes			
Anal fissure	No	Yes			
New fistula	No	Yes			
Abscess	No	Yes			
Liquid stools	No	Yes	If yes, no. of liquid stools a day: _____		
Total HBI score = _____					

CLINICAL ASSESSMENT – ULCERATIVE COLITIS					
SCCAI – circle relevant options below					
	0	1	2	3	4
Wellbeing	Very well	Slightly below par	Poor	Very Poor	Terrible
Bowel frequency (day)	0-3	4-6	7-9	>9	
Bowel frequency (night)	0	1-3	4-6		
Urgency of defecation	None	Hurry	Immediately (toilet nearby)	Incontinence	
Blood in stool	None	Trace	Occasionally frank (<50% of defecation)	Usually frank (>50% of defecation)	
Erythema nodosum	No	Yes			
Pyoderma gangrenosum	No	Yes			
Arthralgia	No	Yes			
Uveitis	No	Yes			
Total SCCAI score = _____					

CLINICAL ASSESSMENT				
PARTIAL MAYO SCORE – circle relevant options below				
	0	1	2	3
Stool frequency	Normal	1-2 more than normal	3-4 more than normal	≥5 more than normal
Rectal bleeding	None	Visible in <50% of stools	Visible in >50% of stools	Frank blood
Physician assessment	Normal	Mild	Moderate	Severe
Total Partial Mayo score = _____ (0-9) <2 remission, 2-4 mild, 5-7 moderate, >7 severe				

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IBD Medication Code			
A – 5-ASA B – Adalimumab C – Azathioprine D – Mercaptopurine E – Methotrexate	F – Infliximab G – Ustekinumab H – Vedolizumab I – Golimumab J – Tofacitinib	K – Steroid (enemas) L – Steroid (suppository) M – Mesalazine (enemas) N – Mesalazine (oral)	O – Mesalazine (suppository) P – Methylprednisolone Q – Prednisolone (oral) U – Budesonide (oral)
Reason for stopping			
R1: Primary non-response – did not respond to drug at all (specify below) R2: Secondary non-response – initially responded then lost response (specify below) R3: Treatment completed R4: Intolerance (specify below) R5: Adverse effect (specify below) R6: Confirmed immunogenicity R7: Other Specify: _____			
Frequency of Use			
F1: Once per day	F2: Twice per day	F3: Three times per day	F4: Four times per day
F5: Once per week	F6: Fortnightly	F7: Monthly	F8: 6 weekly
F9: 8 weekly	F10: 3 monthly	F11: Pro re nata	F12: Alternate days
F13: Six times per day	F14: Five times per day	F15: Other _____	
Drug brand			
B1: Adalimumab- Humira	B2: Adalimumab- Amgevita	B3: Adalimumab- Imraldi	B4: Golimumab- Simponi
B5: Infliximab- Remicade	B6: Infliximab- Inflectra	B7: Infliximab- Remsima	B8: Infliximab- Flixabi
B9: Mesalazine- Octasa	B10: Mesalazine- Asacol	B11: Mesalazine- Mezavant	B12: Mesalazine- Pentasa
B13: Mesalazine- Salofalk	B14: Other _____		

CHANGE IN MAINTENANCE IBD MEDICATIONS					
Has there been a change in maintenance IBD medication since the last visit or a plan to change things at this visit? <input type="checkbox"/> Yes <input type="checkbox"/> No					
*this section is for long-term IBD therapy. For steroid use please fill in the outcomes section.					
Medication 1		Dose	Frequency	Stop date:	Reason for stopping:
Drug name	Brand				
				□□-□□-□□□□	
Medication 2		Dose	Frequency	Stop date:	Reason for stopping:
Drug name	Brand				
				□□-□□-□□□□	
Medication 3		Dose	Frequency	Stop date:	Reason for stopping:
Drug name	Brand				
				□□-□□-□□□□	

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NEW MEDICATIONS				
Medication 1		Dose	Frequency	Start date:
Drug name	Brand			
				□□-□□-□□□□
Medication 2		Dose	Frequency	Start date:
Drug name	Brand			
				□□-□□-□□□□
Medication 3		Dose	Frequency	Start date:
Drug name	Brand			
				□□-□□-□□□□

SIGNIFICANT DOSE CHANGES OF EXISTING THERAPY			
Drug name	Date of change	Description	Reason for change
			<input type="checkbox"/> Drug monitoring guided – step up <input type="checkbox"/> Drug monitoring guided – step down <input type="checkbox"/> Secondary loss of response <input type="checkbox"/> Planned reduction <input type="checkbox"/> Other _____
			<input type="checkbox"/> Drug monitoring guided – step up <input type="checkbox"/> Drug monitoring guided – step down <input type="checkbox"/> Secondary loss of response <input type="checkbox"/> Planned reduction <input type="checkbox"/> Other _____
			<input type="checkbox"/> Drug monitoring guided – step up <input type="checkbox"/> Drug monitoring guided – step down <input type="checkbox"/> Secondary loss of response <input type="checkbox"/> Planned reduction <input type="checkbox"/> Other _____

CURRENT NON-IBD MEDICATIONS		
Has there been a significant change in non-IBD medication since the last visit? <input type="checkbox"/> Yes <input type="checkbox"/> No		
We are interested in proton pump inhibitors, antibiotics, NSAIDs and opiate use.		
Name	Date of change	Description of change

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OUTCOMES

NEW STEROID USE					
Any new courses of oral steroids since the last visit? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Ongoing since last visit					
Steroid Name	Dose	Frequency	Start date:	Stop date:	Reason for use:
			□□-□□-□□□□	□□-□□-□□□□	<input type="checkbox"/> Flare <input type="checkbox"/> Other: _____
Still taken? <input type="checkbox"/> Yes <input type="checkbox"/> No (In NO, Complete Stop date)					
Steroid Name	Dose	Frequency	Start date:	Stop date:	Reason for use:
			□□-□□-□□□□	□□-□□-□□□□	<input type="checkbox"/> Flare <input type="checkbox"/> Other: _____
Still taken? <input type="checkbox"/> Yes <input type="checkbox"/> No (In NO, Complete Stop date)					
Comments:					

NEW FLARES		
Any new flares since the last visit? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Ongoing since last visit		
Approx. timeframe of flare	Description	Brief description of management of flare (community/inpatient/oral steroids/5-ASA/dietetics)
Comments:		

UNPLANNED HOSPITAL ADMISSIONS		
Has the patient had an IBD-related hospital admission since the last visit? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Date of Admission	Date of Discharge	Reason for admission
		<input type="checkbox"/> Acute severe colitis <input type="checkbox"/> Flare not meeting acute severe colitis criteria <input type="checkbox"/> Perianal disease management eg abscess/I&D <input type="checkbox"/> Surgery <input type="checkbox"/> Admission for investigation (not meeting above criteria) <input type="checkbox"/> Other: _____
		<input type="checkbox"/> Acute severe colitis <input type="checkbox"/> Flare not meeting acute severe colitis criteria <input type="checkbox"/> Perianal disease management eg abscess/I&D <input type="checkbox"/> Surgery

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	<input type="checkbox"/> Admission for investigation (not meeting above criteria) <input type="checkbox"/> Other: _____
Comments:	

SURGERY		
Has the patient had an IBD-related surgical procedure since the last visit? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Date of Procedure	Type of Procedure	Comments
	<input type="checkbox"/> Colectomy <input type="checkbox"/> Ileocaecal/small bowel resection <input type="checkbox"/> Other: _____	
	<input type="checkbox"/> Colectomy <input type="checkbox"/> Ileocaecal/small bowel resection <input type="checkbox"/> Other: _____	
Comments:		

CHANGE IN MONTREAL CLASSIFICATION	
Has the patient had a change in Montreal classification since the last visit? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, date of new Montreal classification: □□-□□□-□□□□	
Crohn's Disease	Ulcerative Colitis
Location <input type="checkbox"/> L1 ileal <input type="checkbox"/> L2 colonic <input type="checkbox"/> L3 ileocolonic <input type="checkbox"/> +/- L4 upper GI disease Behaviour <input type="checkbox"/> B1 non-stricturing, non-penetrating <input type="checkbox"/> B2 stricturing <input type="checkbox"/> B3 penetrating <input type="checkbox"/> +/- P perianal disease	Extent <input type="checkbox"/> E1 Proctitis only <input type="checkbox"/> E2 Left-sided UC (distal UC) <input type="checkbox"/> E3 Extensive UC (pancolitis) Severity <input type="checkbox"/> S0 Remission <input type="checkbox"/> S1 Mild UC <input type="checkbox"/> S2 Moderate UC <input type="checkbox"/> S3 Severe UC

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SAMPLE COLLECTION

Blood samples

Were blood samples collected? ☐ Yes ☐ No *If yes, please record date and time collected below*

Serum 4.9ml (NHS) ☐ Yes ☐ No Destination: _____

EDTA 2.7ml (NHS) ☐ Yes ☐ No Destination: _____

EDTA 9/10ml #1 ☐ Yes ☐ No Destination: _____

EDTA 9/10ml #2 ☐ Yes ☐ No Destination: _____

PaxGene ccfDNA ☐ Yes ☐ No Destination: _____

PaxGene RNA ☐ Yes ☐ No Destination: _____

If no, reason not collected: _____

Date Collected: (DD-MM-YYYY) □□-□□-□□□□

Time Collected: (24 Hour Clock) □□:□□

Stool samples

Was a stool sample provided? ☐ Yes ☐ No *If yes, please record date and time collected below*

Faecal calprotectin ☐ Yes ☐ No Destination: _____

qFIT ☐ Yes ☐ No Destination: _____

OmniGut ☐ Yes ☐ No Destination: _____

If no, reason not collected: ☐ Unable to produce ☐ Other: _____

Date Collected: (DD-MM-YYYY) □□-□□-□□□□

Time Collected: (24 Hour Clock) □□:□□

Saliva Sample

Was a saliva sample collected? ☐ Yes ☐ No *If yes, please record date and time collected below*

If no, reason not collected: _____ Destination: _____

Date Collected: (DD-MM-YYYY) □□-□□-□□□□

Time Collected: (24 Hour Clock) □□:□□

REMINDERS

Has patient completed CUCQ32 questionnaire? ☐ Yes ☐ No

Has the patient been provided with sample kits to take home? ☐ Yes ☐ No ☐ N/A

Have the patient's medical records been updated following this visit? ☐ Yes ☐ No