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**R**andomised **E**valuation of **S**urgery with **C**raniectomy for patients

**U**ndergoing **E**vacuation of **A**cute **S**ubdural **H**aematoma

**(RESCUE-ASDH)**

|  |
| --- |
| **Study Questionnaire**  **Health Service EQ5D**  Dear **<patient name>**,  We would be very grateful if you or a relative / friend / carer would agree to complete the following questionnaire. Your participation and co-operation will ensure that the results of the study are reliable and useful in terms of improving the care of patients with acute subdural haematomas.  In this questionnaire, we use the words **“you” and “your”** referring to **<patient name>**. Some people in this study may be unable to fill in these questionnaires themselves. In that case, a relative / friend / carer can fill out the questionnaires, however the words “you” and “your” still refer to **<patient name>** and not the person filling out the questionnaire.  A FREEPOST envelope is provided for return of the questionnaire. Please answer multiple choice questions by putting a in ONE BOX for each question.  ✓  If you do not wish to complete this questionnaire, please return the unanswered questionnaire in the FREEPOST envelope provided.  Your current and future care will not be affected whether you decide to fill out this questionnaire or not. |

**Please complete today’s date below:**

\_\_\_\_\_\_ / \_\_\_\_\_\_ / \_\_\_\_\_\_

Day Month Year

**NOW PLEASE TURN THE PAGE TO START THE QUESTIONNAIRE** ▶

**These questions refer to ALL health services that you have used since leaving the neurosurgical ward on <insert date>.**

Part 1. Hospital Stay

1. **Since you left the neurosurgical ward on <insert date>, have you stayed overnight in a hospital or another healthcare facility for any reason?**

Please also include any overnight stays in a rehabilitation unit.

🞎 NO – GO TO PART 2

🞎 YES – Please give details about the number of stays below

1. For EACH TIME you stayed in hospital or another healthcare facility please answer the following

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **Number of nights**  (approximate) | **Ward speciality**  (type of unit) | **Please tick** (✓) **if this stay was at a Rehabilitation Unit** | **Please tick** (✓) **if this stay included an operation on the skull / brain** |
| Stay 1 |  |  |  |  |
| Stay 2 |  |  |  |  |
| Stay 3 |  |  |  |  |
| Stay 4 |  |  |  |  |
| Stay 5 |  |  |  |  |
| Stay 6 |  |  |  |  |
| Stay 7 |  |  |  |  |
| Stay 8 |  |  |  |  |
| Stay 9 |  |  |  |  |
| Stay 10 |  |  |  |  |

Part 2. Healthcare Professional Contacts

1. **Since you left the neurosurgical ward on <insert date>, have you visited or been visited at home by a healthcare professional about ANY ASPECT of your health?**

Please only include visits that did not include overnight stay in a hospital or another healthcare facility.

🞎 NO – GO TO PART 3

🞎 YES – Please give details about the number of visit(s) below

1. For EACH PROFESSIONAL please answer the following

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  | Please tick (✓) the place where (most) visits took place | | |
| **Healthcare Professional** | **Number of visits**  (approximate) | **Community**  (e.g. GP practice) | **Hospital** | **Home** |
| Hospital Doctor |  |  |  |  |
| Nurse |  |  |  |  |
| General Practitioner (GP) |  |  |  |  |
| Physiotherapist |  |  |  |  |
| Occupational therapist |  |  |  |  |
| Speech therapist |  |  |  |  |
| Social worker |  |  |  |  |
| Community care assistant |  |  |  |  |
| Emergency department visit |  |  |  |  |
| Other (please state)  **…………………………………** |  |  |  |  |
| Other (please state)  **…………………………………** |  |  |  |  |
| Other (please state)  **…………………………………** |  |  |  |  |

Part 3. Help from Family/Friends or other Carers

Examples of the type of help or support include personal care, help in / around the house (e.g. cooking or cleaning), and help outside the home (e.g. shopping).

1. **Have you spent any time in a care home after leaving the neurosurgical ward?**

🞎 NO – GO TO SECTION B

🞎 YES, I spent some time in a care home – please specify:

number of weeks \_\_\_\_\_\_\_\_\_ **OR** months \_\_\_\_\_\_\_\_\_

🞎 YES, I am still currently in a care home – please specify since when:

since \_\_\_\_\_\_\_\_\_ (month) \_\_\_\_\_\_\_\_\_ (year)

1. **Since you left the neurosurgical ward on <insert date>, have you had ANY HELP from a family member / friend or other carer?**

🞎 NO – GO TO PART 4

🞎 YES – Please give details below, excluding information reported above

1. For EACH CARER that helped you please answer the following

|  |  |  |
| --- | --- | --- |
| **Average number of hours of care per week**  **(in the past 12 months)** | **Please tick (✓) if you made a payment for this service** | **Please tick (✓) if this person lives with you** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

Part 4. Head/Brain Scans

1. **Since you left the neurosurgical ward on <insert date>, have you had ANY SCAN of the HEAD/BRAIN?**

🞎 NO – GO TO PART 5

🞎 YES – Please give details about the number of scans on the next page

1. For ANY HEAD/BRAIN SCAN you had please answer the following

|  |  |
| --- | --- |
| **Investigations** | **Number of scans** (approximate) |
| MRI scan of the brain (Magnetic Resonance Imaging) |  |
| CT scan of the brain (Computed Tomography) |  |
| UNKNOWN scan of the brain |  |
| Other (please state)................................................................ |  |
| Other (please state)................................................................ |  |

Part 5. Work

1. **Are you currently working paid / unpaid?**

🞎 NO – GO TO PART 7

🞎 YES – Please answer the questions below before going to part 6

1. **On average, how many hours per week do you work (paid or unpaid work)?**

\_\_\_\_\_\_\_\_\_ Hours

1. **Are you currently working the same hours per week as before your brain injury?**

🞎 YES – GO TO PART 6

🞎 NO – Please answer the question below before going to part 6

1. **Do you work fewer or more hours per week than before your brain injury?**

🞎 FEWER – How many fewer hours per week? \_\_\_\_\_\_\_\_\_\_\_

🞎 MORE – How many more hours per week? \_\_\_\_\_\_\_\_\_\_\_

Part 6. Returned to work

1. **Please tell us the date (approximately) that you returned to work (part or full time, paid or unpaid) following your brain injury?**

\_\_\_\_\_\_ / \_\_\_\_\_\_ / \_\_\_\_\_\_

Day Month Year

1. **Since you returned to work, have you taken any days off work due to sickness?**

🞎 NO – GO TO PART 7

🞎 YES – Please complete the table below before going to part 7

|  |  |
| --- | --- |
|  | **Number of days off**  **(approximate)** |
| Absence 1 |  |
| Absence 2 |  |
| Absence 3 |  |
| Absence 4 |  |
| Absence 5 |  |
|  |  |

Part 7. Work Situation Changed

1. **Have you had to leave work / change your job course since your brain injury?**

🞎 NO – GO TO PART 8

🞎 YES – Please answer the question below before going to part 8

1. **Please explain why you have left work or changed your job?**

Please tick (✓) one box

🞎 I have **left** work **due to my brain injury**

🞎 I have **changed** my job **due to my brain injury**

🞎 I have **left** work for **reasons not related to my brain injury**

🞎 I have **changed** my job for **reasons not related to my brain injury**

Part 8. Health Outcomes Measures

1. **Please let us know who completed this questionnaire**

Please tick (✓) one box

🞎 **<patient name>** alone – GO TO PART 9

🞎 **<patient name>** with help – GO TO PART 9

🞎 Relative / friend / carer – GO TO PART 10

Part 9. EQ-5D™ Questionnaire

Under each heading, please tick the ONE box that best describes your health TODAY

**MOBILITY**

I have no problems in walking about ❑

I have slight problems in walking about ❑

I have moderate problems in walking about ❑

I have severe problems in walking about ❑

I am unable to walk about ❑

**SELF-CARE**

I have no problems washing or dressing myself ❑

I have slight problems washing or dressing myself ❑

I have moderate problems washing or dressing myself ❑

I have severe problems washing or dressing myself ❑

I am unable to wash or dress myself ❑

**USUAL ACTIVITIES** *(e.g. work, study, housework, family or leisure activities)*

I have no problems doing my usual activities ❑

I have slight problems doing my usual activities ❑

I have moderate problems doing my usual activities ❑

I have severe problems doing my usual activities ❑

I am unable to do my usual activities ❑

**PAIN / DISCOMFORT**

I have no pain or discomfort ❑

I have slight pain or discomfort ❑

I have moderate pain or discomfort ❑

I have severe pain or discomfort ❑

I have extreme pain or discomfort ❑

**ANXIETY / DEPRESSION**

I am not anxious or depressed ❑

I am slightly anxious or depressed ❑

I am moderately anxious or depressed ❑

I am severely anxious or depressed ❑

I am extremely anxious or depressed ❑

10

0

20

30

40

50

60

80

70

90

100

5

15

25

35

45

55

75

65

85

95

The best health   
 you can imagine

The worst health   
 you can imagine

* We would like to know how good or bad your health is TODAY.
* This scale is numbered from 0 to 100.
* 100 means the best health you can imagine.  
  0 means the worst health you can imagine.
* Mark an X on the scale to indicate how your health is TODAY.
* Now, please write the number you marked on the scale in the box below.

YOUR HEALTH TODAY =

**-THIS WAS THE LAST QUESTION OF THE QUESTIONNAIRE-**

**PLEASE GO TO PART 11** ▶

Part 10. EQ-5D™ Questionnaire (proxy)

By placing a tick in one box in each group below, please indicate which statements **the person you care for** would choose to describe his/her health state TODAY if he/she could tell us.

**MOBILITY**

No problems in walking about ❑

Slight problems in walking about ❑

Moderate problems in walking about ❑

Severe problems in walking about ❑

Unable to walk about ❑

**SELF-CARE**

No problems washing or dressing him/herself ❑

Slight problems washing or dressing him/herself ❑

Moderate problems washing or dressing him/herself ❑

Severe problems washing or dressing him/herself ❑

Unable to wash or dress him/herself ❑

**USUAL ACTIVITIES** *(e.g. work, study, housework, family or leisure activities)*

No problems doing his/her usual activities ❑

Slight problems doing his/her usual activities ❑

Moderate problems doing his/her usual activities ❑

Severe problems doing his/her usual activities ❑

Unable to do his/her usual activities ❑

**PAIN / DISCOMFORT**

No pain or discomfort ❑

Slight pain or discomfort ❑

Moderate pain or discomfort ❑

Severe pain or discomfort ❑

Extreme pain or discomfort ❑

**ANXIETY / DEPRESSION**

Not anxious or depressed ❑

Slightly anxious or depressed ❑

Moderately anxious or depressed ❑

Severely anxious or depressed ❑

Extremely anxious or depressed ❑

10

0

20

30

40

50

60

80

70

90

100

5

15

25

35

45

55

75

65

85

95

The best health   
 imaginable

The worst health imaginable

* We would like to know how good or bad you think **the person you care for** would say his/her health is TODAY, if he/she could tell us.
* This scale is numbered from 0 to 100.
* 100 means the best health imaginable.  
  0 means the worst health imaginable.
* Mark an X on the scale to indicate how good or bad you think **the person you care for** would say his/her health is TODAY.
* Now, please write the number you marked on the scale in the box below.

**The person you care for** would rate his/her OWN HEALTH TODAY AS:

**-THIS WAS THE LAST QUESTION OF THE QUESTIONNAIRE-**

**PLEASE GO TO PART 11** ▶

Part 11. Comments

Your comments are important to us. Please feel free to provide any other comments you have in the box below.

Thank you for your help!

Updates about the study can be found at [www.website.org](http://www.website.org). If you would like to ask us any questions about completing this questionnaire please email or call:

RESCUE-ASDH co-ordinator

🖂 email@website.org

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