City of Hope

Demography & Health Status
Pancreatic

inTeleScans powered by Teleform

Protocol ID: ProtocolID

Research Participant #: RPN

Participant Initials: PartInitials

Evaluation Code: EvaluationCode

Because this is a computer read form, please use **BLACK ink only.** Please solidly fill bubbles for choice responses.

Date of Form Completion: FormCompletionDate (month / day / year)

Demographics & Disease Data

1. Date of Birth: BirthDate (month / day / year)

Gender your gender?
Male ale Female ale

2. Is your ethnicity Hispanic, Ethnicity icano?
1 Yes 0 No

Race race do you consider yourself?
1 White 3 American Indian or Alaska Native 4 Asian
6 Other 2 Black or African American 5 Native Hawaiian or Other Pacific Islander

Specify: SKFIRace

3. Education highest grade or level of school you have completed? (select only one response)
1 1 - 8 years (grade school)
2 9 - 12 years (high school), but did not graduate
3 High school diploma or GED
4 Vocational school/Technical school/Other training after high school (except college)
5 Some college
6 2 year college degree (e.g. Associate of Arts)
7 4 year college degree (e.g. Bachelor of Arts/Science)
8 Professional or graduate school (e.g. Master's, Doctorate)
9 Other, specify: SKFILevelSchoolCompleted

4. MaritalStatus tal status?
1 Never married 3 Widowed 5 Divorced
2 Separated 4 Married 6 Other, specify: SKFIMaritalStatus

5. EmploymentStatus mployment status? Include unpaid work in the family business or farm. (Select all that apply)
1 Employed full-time 5 Part-time student 9 Homemaker
2 Employed part-time 6 Permanently disabled 10 Other, specify: SKFIWorkStatus
3 Retired 7 On temporary medical leave
4 Full-time student 8 Unemployed or seeking work

6. AnnualHouseholdIncome f your household?
1 Less than $15,000 2 $15,000 to $30,000 3 $30,001 to $50,000
4 $50,001 to $75,000 5 $75,001 to $100,000 6 Greater than $100,000

Protocol ID: _____ Research Participant #: _____ Participant Initials: _____ Evaluation Code: _____

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Demographics & Disease Data (Continued)

7. Religion ur religious preference?

- 1 Protestant (e.g. Methodist, Baptist, Lutheran, etc.)
- 2 Buddhist
- 3 Catholic
- 4 Mormon
- 5 Jewish
- 6 Jehovah's Witness
- 7 Muslim
- 8 Seventh Day Adventist
- 9 None
- 10 Other, explain: SKFIReligion _____

8. HowFarTravel travel for your cancer care?

1 Less than 5 miles 2 5 to 10 miles 3 10 to 15 miles 4 More than 15 miles

Other Health Problems

We would like to ask you a few questions about any **other health problems** that you might have. Do you have any of the following illnesses at the present time?

Please select the appropriate response (yes or no). If you select "yes" please tell us how much the illness interferes with your activities.

			If you have this illness: How much does it interfere with your activities?		
Illness	No	Yes	Not at All	Somewhat	A Great Deal
1. Arthritis or rheumatism	OthIllnessArthritisRheumatism 0	1	2	3	4
2. Emphysema/Chronic Obstructive Pulmonary Disease (COPD)	OthIllnessEmphysemaCOPD 0	1	2	3	4
3. High blood pressure	OthIllnessHighBloodPressure 0	1	2	3	4
4. Heart disease	OthIllnessHeartDisease 0	1	2	3	4
5. Circulation trouble in arms or legs	OthIllnessCirculationTrouble 0	1	2	3	4
6. Diabetes	OthIllnessDiabetes 0	1	2	3	4
7. Stomach or intestinal disorders	OthIllnessStomachIntestDisorders 0	1	2	3	4
8. Osteoporosis	OthIllnessOsteoporosis 0	1	2	3	4
9. Chronic Liver or Kidney disease	OthIllnessChronicLiverKidneyDis 0	1	2	3	4
10. Stroke	OthIllnessStroke 0	1	2	3	4
11. Depression	OthIllnessDepression 0	1	2	3	4
12. Other, specify: SKFICoMorbidityOther _____	OthIllnessOther 0	1	2	3	4

Protocol ID: _____ Research Participant #: _____ Participant Initials: _____ Evaluation Code: _____

Because this is a computer read form, please use **BLACK ink only.** Please solidly fill bubbles for choice responses.

The following items are types of support that you might receive from your family and/or friends. Please select the appropriate response that describes whether you have the following kinds of support.

Kinds of Support	None of the time	A little of the time	Some of the time	Most of the time	All of the time
1. Someone to help if you were confined to bed.	SupportConfinedToBed 0	1	2	3	4
2. Someone you can count on to listen to you when you need to talk.	SupportSomeoneToListen 0	1	2	3	4
3. Someone to give you good advice about a crisis.	SupportAdviceReCrisis 0	1	2	3	4
4. Someone to take you to the doctor if needed.	SupportTakeToDr 0	1	2	3	4
5. Someone to give you information to help you understand a situation.	SupportInfoHelpUnderstandSitu 0	1	2	3	4
6. Someone to confide in or talk to about yourself or your problem.	SupportConfideInReProblem 0	1	2	3	4
7. Someone to prepare your meals if you were unable to do it yourself.	SupportPrepMeals 0	1	2	3	4
8. Someone whose advice you really want.	SupportAdvice 0	1	2	3	4
9. Someone to help you with daily chores if you were sick.	SupportDailyChores 0	1	2	3	4
10. Someone to share your most private worries and fears with.	SupportPrivateWorries 0	1	2	3	4
11. Someone to turn to for suggestions about how to deal with a personal problem.	SupportSuggRePersonalProblem 0	1	2	3	4
12. Someone who understands your problems.	SupportSomeoneWhoUnderstandsProb 0	1	2	3	4

City of Hope

Activities of Daily Living

inTeleScans powered by Teleform

Protocol ID: ProtocolID

Research Participant # RPN

Participant Initials: PartInitials

Evaluation Code EvaluationCode

Because this is a computer read form, please use **BLACK ink only.** Please solidly fill bubbles for choice responses.

Date of Form Completion: FormCompletionDate (month / day / year)

Please check one response for each question.

1. Telephone) the telephone...
   - 1 without help, including looking up and dialing?
   - 2 with some help (able to answer phone or dial operator in an emergency, but need a special phone or help in getting the number or dialing)?
   - 3 Are you completely unable to use the telephone?

2. Travel) get to places out of walking distance...
   - 1 without help (Drive your own car, or travel alone on buses, or taxis)?
   - 2 with some help (need someone to help you or go with you when traveling)?
   - 3 Are you unable to travel unless emergency arrangements are made for a specialized vehicle like an ambulance?

3. Shopping) shopping for groceries or clothes (assuming you have transportation)...
   - 1 without help (taking care of all shopping needs yourself, assuming you have transportation)?
   - 2 with some help (need someone to go with you on all shopping trips)?
   - 3 Are you completely unable to do any shopping?

4. MealPrep epare your own meals...
   - 1 without help (plan and cook full meals yourself)?
   - 2 with some help (able to prepare some things but unable to cook full meals yourself)?
   - 3 Are you completely unable to prepare any meals?

5. Housework your housework...
   - 1 without help (able to clean floors, etc.)?
   - 2 with some help (able to do light housework, but need help with heavy work)?
   - 3 Are you completely unable to do any housework?

6. Medicine ke your own medicines...
   - 1 without help (in the right doses at the right time)?
   - 2 with some help (able to take medicine if someone prepares it for you and/or reminds you to take it)?
   - 3 Are you completely unable to take your medicines?

7. Finance ıandle your own money...
   - 1 without help (write checks, pay bills, etc.)?
   - 2 with some help (manage day-to day buying, but need help with managing your checkbook and paying your bills)?
   - 3 Are you completely unable to handle money?

COHADM3021v00 Rev: 01/09/2015

0 0 0 1

18667

Annotations modified: 1/9/2015

CarBITS.dbo.NurseActivities (vNurseActivities)

Protocol ID:	Research Participant #:	Participant Initials:	Evaluation Code:

Because this is a computer read form, please use **BLACK ink only.** Please solidly fill bubbles for choice responses.

8. Bathing g bathing (sponge, tub bath, or shower), do you...
   - 1 need no assistance (bathe your entire body on your own)?
   - 2 need assistance in bathing only one part of body (such as back or a leg)?
   - 3 need assistance in bathing more than one part of body (or not bathed)?

9. Dressing Regarding dressing (getting clothes from closets and drawers, including underclothes, outer garments and ners), do you...
   - 1 retrieve clothes and get completely dressed without assistance?
   - 2 retrieve clothes and get dressed without assistance (except for assistance with tying shoes)?
   - 3 need assistance in retrieving clothes or getting dressed, or stay partly or completely undressed?

10. Toileting Regarding toileting (going to bathroom for bowel and urine elimination, cleaning self after elimination and arranging you...
    - 1 go to the bathroom, clean self and arrange clothes without assistance (may use object for support, such as a cane, walker, or wheelchair and may manage night bedpan, or commode; emptying same in AM)?
    - 2 need assistance for any aspect of toileting?
    - 3 not go to bathroom for elimination process?

11. Transfer transfering, do you...
    - 1 move in and out of chair without assistance (may use object for support such as cane or walker)?
    - 2 move in and out of bed or chair with assistance?
    - 3 not get out of bed?

12. Continence ntinence, do you...
    - 1 control urination and bowel movement completely by yourself?
    - 2 have occasional "accidents?"
    - 3 use a catheter or are you incontinent (supervision helps keep urine or bowel in control)?

13. Eating ng eating, do you...
    - 1 feed yourself without assistance?
    - 2 feed yourself (except for assistance with cutting meat or buttering bread)?
    - 3 need assistance with feeding or are fed partly or completely using tubes or intravenous fluids?

Medical Record Abstraction

inTeleScans powered by Teleform

Protocol ID: ProtocolID

Research Participant #: RPN

Evaluation Code: EvaluationCode

Form #: FormNo

Because this is a computer read form, please use **BLACK ink only.** Please solidly fill bubbles for choice responses.

Date of Form Completion: FormCompletionDate (month / day / year)

DIAGNOSIS AND CLINICAL INFORMATION

DzStage

Stage of Disease (Check one): 1 III 2 IV

TNM Classification of Malignant Tumors (TNM): PathTStage PathNStage PathMStage

T N M

Date of Initial Diagnosis: InitialDxDate (month / day) / RecurrentDzYN

Was this diagnosis a recurrent disease? (check one) 1 Yes 0 No 2 Not Recorded

HEALTHCARE UTILIZATION

HospitalAdmission

Hospital Admissions: 2 None 1 Yes → If yes, admission Date: HospitalAdmissionDate (month / day / year)

AdmissionReason:

1 Symptom Management
2 Additional Surgical Procedures
3 Infection
4 Other: SKFIAdmissionReason

Hospital Discharge Date: HospitalDischargeDate (month / day / year)

DischargeDisposition

1 Home or paid home care assistance
2 Home – independent care (unpaid)
3 Inpatient facility
4 SNF/Rehab/Nursing home
5 Other: SKFIDischargeDisposition

UnscheduledOutpatientEncounterYN

Unscheduled Outpatient Encounters: 2 None 1 Yes → If yes, complete the following:

EncounterType

Type of Encounter: 1 Clinic 2 Phone call

EncounterSource:

1 Cardiology
2 Endocrinology
3 ETC
4 Imaging (CT, PET, MR, etc)
5 Lab
6 Medical Oncology
7 Neurology
8 Nutrition
9 Pain/Palliative Care
10 Psychology/Psychiatry
11 PT/OT/Incontinence Program
12 Pulmonologist
13 Pulmonary Rehabilitation
14 Radiation Oncology
15 Social Services
16 Surgery
17 Other: SKFIEncounterSource

EncounterReason

Reason for Encounter: 1 Consultation 2 Education/Counseling 3 Symptom Management

Medical Record Abstraction

inTeleScans powered by Teleform

Protocol ID: _____ Research Participant #: _____ Evaluation Code: _____ Form #: _____

Because this is a computer read form, please use **BLACK ink only.** Please solidly fill bubbles for choice responses.

ZATION (Continued)

COHSupportReferralYN

COH Supportive Care Referrals: 2 None 1 Yes

→ If yes, check all services that patient received in table below.

For each referral, check whether the patient actually was seen by the service. Select pending if a referral was scheduled with an actual date available.

SupportServicesReferred	SupportServicesReceivedYN			
1 Biller Resources Center/Patient Education	1 Yes	0 No	-9 Unknown	2 Pending
○ Chaplaincy	○ Yes	○ No	○ Unknown	○ Pending
○ Nutrition	○ Yes	○ No	○ Unknown	○ Pending
○ Pain/Palliative Care	○ Yes	○ No	○ Unknown	○ Pending
○ Psychology/Psychiatry	○ Yes	○ No	○ Unknown	○ Pending
○ PT/OT/Incontinence Program	○ Yes	○ No	○ Unknown	○ Pending
○ Pulmonary Rehabilitation	○ Yes	○ No	○ Unknown	○ Pending
○ Social Services	○ Yes	○ No	○ Unknown	○ Pending
○ Other SKFISupportServicesReferredOther	○ Yes	○ No	○ Unknown	○ Pending

COHMedicalReferralYN

Other COH Medical Specialists Referrals: 2 None 1 Yes

→ If yes, check all services that patient received in table below.

For each referral, check whether the patient actually was seen by the service. Select pending if a referral was scheduled with an actual date available.

SupportServicesReferred	SupportServicesReceivedYN			
1 Cardiology	1 Yes	0 No	-9 Unknown	2 Pending
○ Endocrinology	○ Yes	○ No	○ Unknown	○ Pending
○ Neurology	○ Yes	○ No	○ Unknown	○ Pending
○ Pulmonology	○ Yes	○ No	○ Unknown	○ Pending
○ Other SKFIMedicatServicesReferredOther	○ Yes	○ No	○ Unknown	○ Pending

RecurrenceYN

Did patient have a recurrence while on study? 1 Yes 0 N

DzProgressionYN

Did patient experience disease

PtCompleteStatus

study? 1 Yes 0 No

Status at completion of study: 1 Alive 2 Deceased

→ If deceased, date of death DeceaseDate ___ / ___ / ____

month day year

Form Completion Information

Completed By: Nurse ID: NurseID

Date Completed: CRACompleteDate ___ / ___ / ____

Date Reviewed: PhysReviewDate ___ / ___ / ____

month day year

Reviewed By FULL NAME (Please Print)

18665

CarBITS.dbo.NurseMedRecAbstractionDetail (vNurseMedRecAbstractionDetail)

Annotations modified: 1/14/2015

CarBITS.dbo.NurseMedRecAbstractionMaster (vNurseMedRecAbstractionMaster)

City of Hope

Debriefing for 14273

inTeleScans powered by Teleform

Protocol ID: ProtocolID

Research Participant #: RPN

Participant Initials: PartInitials

Evaluation Code: EvaluationCode

Because this is a computer read form, please use **BLACK ink only.** Please solidly fill bubbles for choice responses.

Date of Form Completion: FormCompletionDate (month / day / year)

1. PresentInSession ent during the session:
   - 1 Patient
   - 2 Other
     - If other, specify relationship with patient: SKFIPresentInSession

SessionCombineYN

2. Were the two teaching sessions combined into one? 1 Yes 0 No

3. Length of session(s) in minutes:
   - Session #1: SessionLength1 minutes
   - Session #2: SessionLength2 minutes
   - Combined: SessionLengthCombine minutes

4. DeliverMode y:
   - 1 Face to Face
   - 2 Telephone
   - 3 Other:
     - If other, specify: SKFIDeliverMode

5. Topics selected:

SessionTopic1 ical and Emotional Well-Being

- 1 Pain/ Neuropathy
- 2 Constipation
- 3 Fatigue
- 4 Lack of Appetite and Weight Loss
- 5 Nausea and Vomiting
- 6 Lack of Sleep
- 7 Anxiety
- 8 Depression

SessionTopic2 al and Spiritual Well-Being

- 1 Family Needs
- 2 Communication
- 3 Sexuality
- 4 Social Support
- 5 Healthcare Planning
- 6 Meaning of Illness
- 7 Religious/ Spiritual Support

Protocol ID:	Research Participant #:	Participant Initials:	Evaluation Code:

Because this is a computer read form, please use **BLACK ink only.** Please solidly fill bubbles for choice responses.

6. Give your overall impr[illegible] OverallSessionImpression

Not at all effective 0 1 2 3 4 5 6 7 8 9 10 Very effective

7. How responsive was th[illegible] sessions? PtResponsive

Not at all responsive 0 1 2 3 4 5 6 7 8 9 10 Very responsive

8. In general, how do you [illegible] anaging physically? PtPhysicalManage

Very poorly 0 1 2 3 4 5 6 7 8 9 10 Very well

9. In general, how do you [illegible] managing emotionally? PtEmotionManage

Very poorly 0 1 2 3 4 5 6 7 8 9 10 Very well

Please identify other issues that may have influenced the sessions.

OtherIssues

Please document any other comments you have concerning the sessions.

Comments

0 0 0 1

17804

Annotations modified: 1/9/2015

CarBITS.dbo.NurseDebrief14273 (vNurseDebrief14273)

FACT-G (Version 4)

Protocol ID: ProtocolID

Research Participant #: RPN

Evaluation Code: EvaluationCode

Because this is a computer read form, please use **BLACK ink only.** Please solidly fill bubbles for choice responses.

Date of Form Completion: FormCompletionDate (month / day / year)

Below is a list of statements that other people with your illness have said are important. Please select one bubble per line to indicate your response as it applies to the **past 7 days**.

PHYSICAL WELL-BEING

	Not at all	A little bit	Somewhat	Quite a bit	Very much
I have a lack of energy (HaveLackOfEnergy)	0	1	2	3	4
I have nausea (HaveNausea)	0	1	2	3	4
Because of my physical condition, I have trouble meeting the needs of my family (HaveTroubleMeetNeedsOfFam)	0	1	2	3	4
I have pain (HavePain)	0	1	2	3	4
I am bothered by side effects of treatment (BotheredBySideEffectsTrtmt)	0	1	2	3	4
I feel ill (FeelIll)	0	1	2	3	4
I am forced to spend time in bed (ForcedSpndTmBed)	0	1	2	3	4

SOCIAL/FAMILY WELL-BEING

	Not at all	A little bit	Somewhat	Quite a bit	Very much
I feel close to my friends (FeelCloseToFrnds)	0	1	2	3	4
I get emotional support from my family (GetEmotionalSuppFrFamily)	0	1	2	3	4
I get support from my friends (GetSupportFrFrnds)	0	1	2	3	4
My family has accepted my illness (FamAcceptIllness)	0	1	2	3	4
I am satisfied with family communication about my illness (SatisfiedWFamCommunicationRelIll)	0	1	2	3	4
I feel close to my partner (or the person who is my main support) (FeelCloseToPartner)	0	1	2	3	4

Regardless of your current level of sexual activity, please answer the following question.

If you prefer not to answer it, please check this box SFWB6NoAnswer [1] *and go to the next section.*

	Not at all	A little bit	Somewhat	Quite a bit	Very much
I am satisfied with my sex life (SatisfiedWithSexLife)	0	1	2	3	4

COHADM3024v00 Rev: 01/13/2015

17803

Annotations modified: 1/13/2015

CarBITS.dbo.NurseFACTG (vNurseFACTG)

FACT-G (Version 4)

Protocol ID: _____ Research Participant #: _____ Evaluation Code: _____

Because this is a computer read form, please use **BLACK ink only.** Please solidly fill bubbles for choice responses.

By selecting one (1) bubble per line, please indicate your response as it applies to **the past 7 days**.

EMOTIONAL WELL-BEING

	Not at all	A little bit	Somewhat	Quite a bit	Very much
I feel sad (FeelSad)	0	1	2	3	4
I am satisfied with how I am coping with my illness (CopingWithIllness)	0	1	2	3	4
I am losing hope in the fight against my illness (LosingHope)	0	1	2	3	4
I feel nervous (FeelNervous)	0	1	2	3	4
I worry about dying (WorryReDying)	0	1	2	3	4
I worry that my condition will get worse (WorryCondGetWorse)	0	1	2	3	4

FUNCTIONAL WELL-BEING

	Not at all	A little bit	Somewhat	Quite a bit	Very much
I am able to work (include work at home) (AbleToWork)	0	1	2	3	4
My work (include work at home) is fulfilling (WorkFulfilling)	0	1	2	3	4
I am able to enjoy life (EnjoyLife)	0	1	2	3	4
I have accepted my illness (AcceptIllness)	0	1	2	3	4
I am sleeping well (SleepWell)	0	1	2	3	4
I am enjoying the things I usually do for fun (EnjoyFun)	0	1	2	3	4
I am content with the quality of my life right now (ContentQOLNow)	0	1	2	3	4

17803

0 0 0 1

Annotations modified: 1/13/2015

CarBITS.dbo.NurseFACTG (vNurseFACTG)

City of Hope

FACT-Hep (Version 4)

inTeleScans powered by Teleform

Protocol ID: ProtocolID

Research Participant # RPN

Evaluation Code: EvaluationCode

Because this is a computer read form, please use **BLACK ink only.** Please solidly fill bubbles for choice responses.

Date of Form Completion: FormCompletionDate (month / day / year)

By selecting one (1) bubble per line, please indicate your response as it applies to **the past 7 days**.

	Not at all	A little bit	Somewhat	Quite a bit	Very much
I have swelling or cramps in my stomach area	SwellCrampsInStomach 0	1	2	3	4
I am losing weight	LosingWeight 0	1	2	3	4
I have control of my bowels	HaveControlOfBowels 0	1	2	3	4
I can digest my food well	CanDigestFoodWell 0	1	2	3	4
I have diarrhea	HaveDiarrhea 0	1	2	3	4
I have a good appetite	HaveGoodAppetite 0	1	2	3	4
I am unhappy about a change in my appearance	UnhappyReChgAppearance 0	1	2	3	4
I have pain in my back	HavePainInBack 0	1	2	3	4
I am bothered by constipation	BotheredByConstipation 0	1	2	3	4
I feel fatigued	IFeelFatigued 0	1	2	3	4
I am able to do my usual activities	AbleToDoUsualActivities 0	1	2	3	4
I am bothered by jaundice or yellow color to my skin	BotheredByJaundice 0	1	2	3	4
I have had fevers	HavehadFevers 0	1	2	3	4
I have had itching	HaveHadItching 0	1	2	3	4
I have had a change in the way food tastes	HadChgInWayFoodTastes 0	1	2	3	4
I have had chills	HaveHadChills 0	1	2	3	4
My mouth is dry	MyMouthIsDry 0	1	2	3	4
I have discomfort or pain in my stomach area	HaveDiscomfortPainInStomach 0	1	2	3	4

17802

Annotation modified: 1/14/2015

CarBITS.dbo.NurseFACTHep (vNurseFACTHep)

Hospital Anxiety and Depression Scale (HADS)

City of Hope

inTeleScans powered by Teleform

Protocol ID: ProtocolID

Research Participant #: RPN

Evaluation Code: EvaluationCode

Because this is a computer read form, please use **BLACK ink only.** Please solidly fill bubbles for choice responses.

Date of Form Completion: FormCompletionDate (month / day / year)

Instructions: Read each item and fill in the bubble for the choice which comes closest to how you have been feeling, on average, **in the past week**. Don't take too long; your immediate reaction to each item will probably be more accurate than a long thought out response.

1. FeelTense r "wound up:"
   - 1 Most of the time
   - 2 A lot of the time
   - 3 From time to time, occasionally
   - 4 Not at all

2. StillEnjoyThings used to enjoy:
   - 1 Definitely as much
   - 2 Not quite so much
   - 3 Only a little
   - 4 Hardly at all

3. FrightenedFeeling feeling as if something awful is about to happen:
   - 1 Very definitely and quite badly
   - 2 Yes, but not too badly
   - 3 A little, but it doesn't worry me
   - 4 Not at all

4. ICanLaugh and see the funny side of things:
   - 1 As much as I always could
   - 2 Not quite so much now
   - 3 Definitely not so much now
   - 4 Not al all

5. WorryingThoughts through my mind:
   - 1 A great deal of the time
   - 2 A lot of the time
   - 3 From time to time, but not often
   - 4 Only occasionally

6. FeelCheerful
   - 1 Not at all
   - 2 Not often
   - 3 Sometimes
   - 4 Most of the time

7. CanSitAtEase and feel relaxed:
   - 1 Definitely
   - 2 Usually
   - 3 Not often
   - 4 Not at all

8. FeelSlowedDown ved down:
   - 1 Nearly all the time
   - 2 Very often
   - 3 Sometimes
   - 4 Not at all

COHADM3026v00 Rev: 01/13/2015

18662

Annotations modified: 1/13/2015

CarBITS.dbo.NurseHADS (vNurseHADS)

Hospital Anxiety and Depression Scale (HADS)

inTeleScans powered by Teleform

Protocol ID:	Research Participant #:	Participant Initials:	Evaluation Code:

Because this is a computer read form, please use **BLACK ink only.** Please solidly fill bubbles for choice responses.

9. GetFrightenedFeeling ling like "butterflies" in the stomach:

- 1 Not at all
- 2 Occasionally
- 3 Quite often
- 4 Very often

10. LostIntInAppearance ppearance:

- 1 Definitely
- 2 I don't take as much care as I should
- 3 I may not take quite as much care
- 4 I take just as much care as ever

11. FeelRestless if I have to be on the move:

- 1 Very much indeed
- 2 Quite a lot
- 3 Not very much
- 4 Not at all

12. LookFwdWithEnjoyment nt to things:

- 1 As much as ever I did
- 2 Rather less than I used to
- 3 Definitely less than I used to
- 4 Hardly at all

13. GetFeelingsOfPanic panic:

- 1 Very often indeed
- 2 Quite often
- 3 Not very often
- 4 Not at all

14. EnjoyGoodBook d book or radio or TV program:

- 1 Often
- 2 Sometimes
- 3 Not often
- 4 Very seldom

City of Hope

EvalID EvalTime

Report of Health Care Services

inTeleScans powered by Teleform

Protocol ID: ProtocolID

Research Participant #: RPN

Participant Initials: PartInitials

Evaluation Code: EvaluationCode

29572

Because this is a computer read form, please use **BLACK ink only.** Please solidly fill bubbles for choice responses.

Date of Form Completion: FormCompletionDate (month / day / year)

Since being on the study, have you visited or used any of the following health care services?

Health Care Service	Service Used?	Frequency: (# of visits)	Date(s) (month / day / year)	Length: (minutes, hours, or days)	Amount: (How many?)	Scheduled Visit? No	Scheduled Visit? Yes
1. Hospital	○ 1 HCSUsedHosp	HCSHospFreq	HCSHospDate	HCSHospLgth ○ m ○ h ○ d 1 2 3 HCSHospLgthUnit	HCSHospAmt	○ 0	○ 1 HCSHospSchedVstYN
2. Emergency Room	○ 1 HCSUsedER	HCSERFreq	HCSERDate	HCSERLgth ○ m ○ h ○ d 1 2 3 HCSERLgthUnit	HCSERAmt	○ 0	○ 1 HCSERSchedVstYN
3. Oncologist	○ 1 HCSUsedOnc	HCSOncFreq	HCSOncDate	HCSOncLgth ○ m ○ h ○ d 1 2 3 HCSOncLgthUnit	HCSOncAmt	○ 0	○ 1 HCSOncSchedVstYN
4. Surgeon	○ 1 HCSUsedSurg	HCSSurgFreq	HCSSurgDate	HCSSurgLgth ○ m ○ h ○ d 1 2 3 HCSSurgLgthUnit	HCSSurgAmt	○ 0	○ 1 HCSSurgSchedVstYN
5. Primary Care Provider	○ 1 HCSUsedPCP	HCSPCPFreq	HCSPCPDate	HCSPCPLgth ○ m ○ h ○ d 1 2 3 HCSPCPLgthUnit	HCSPCPAmt	○ 0	○ 1 HCSPCPSchedVstYN
6. Specialist	○ 1 HCSUsedSpec	HCSSpecFreq	HCSSpecDate	HCSSpecLgth ○ m ○ h ○ d 1 2 3 HCSSpecLgthUnit	HCSSpecAmt	○ 0	○ 1 HCSSpecSchedVstYN
7. Skilled Nursing Facility	○ 1 HCSUsedSkillRNFac	HCSSkillRNFacFreq	HCSSkillRNFacDate	HCSSkillRNFacLgth ○ m ○ h ○ d 1 2 3 HCSSkillRNFacLgthUnit	HCSSkillRNFacAmt	○ 0	○ 1 HCSSkillRNFacSchedVstYN
8. Visiting Nurse	○ 1 HSCUsedVstRN	HCSVstRNFreq	HCSVstRNDate	HCSVstRNLgth ○ m ○ h ○ d 1 2 3 HCSVstRNLgthUnit	HCSVstRNAmt	○ 0	○ 1 HCSVstRNSchedVstYN
9. Complementary Therapies	○ 1 HCSUsedCompTx	HCSCompTxFreq	HCSCompTxDate	HCSCompTxLgth ○ m ○ h ○ d 1 2 3 HCSCompTxLgthUnit	HCSCompTxAmt	○ 0	○ 1 HCSCompTxSchedVstYN
10. **Rehabilitation Services** Therapy: Physical, Occupational, Speech and/or Respiratory	○ 1 HCSUsedRehabServ	HCSRehabServFreq	HCSRehabServDate	HCSRehabServLgth ○ m ○ h ○ d 1 2 3 HCSRehabServLgthUnit	HCSRehabServAmt	○ 0	○ 1 HCSRehabSerSchedVstYN
11. **Counseling Services:** Social Worker, Psychiatrist, Psychologist	○ 1 HCSUsedCnslServ	HCSCnslServFreq	HCSCnslServDate	HCSCnslServLgth ○ m ○ h ○ d 1 2 3 HCSCnslServLgthUnit	HCSHCSCnslServAmt	○ 0	○ 1 HCSHCSCnslServSchedVstYN
12. Supportive Services	○ 1 HCSUsedSpptServ	HCSSpptServFreq	HCSSpptServDate	HCSSpptServLgth ○ m ○ h ○ d 1 2 3 HCSSpptServLgthUnit	HCSHCSSpptServAmt	○ 0	○ 1 HCSSpptServSchedVstYN
13. Other Services, please specify: SKFIHCSServOth	○ 1 HCSUsedOthServ	HCSOthServFreq	HCSOthServDate	HCSOthServLgth ○ m ○ h ○ d 1 2 3 HCSOthServLgthUnit	HCSHCSOthServAmt	○ 0	○ 1 HCSHCSOthServSchedVstYN

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COHADM3027v00 Rev: 03/02/2015

Annotations modified: 3/2/2015

Carbits.dbo.NurseHealthCare (vNurseHealthCare)

City of Hope

Report of Health Care Services

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	1	2	3	4	5	6	7	8	9	10	11	12	13
Reason for using service	Hospital	ER	Surgeon	Oncologist	Primary Care Provider	Specialist	Skilled Nursing Facility	Visiting Nurse	Complemetary Therapies	Rehab	Counseling Services	Supportive Services	Other
CANCER-RELATED SERVICES													
1. Chemotherapy	○ 1	○ CARelatedChemo 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8	○ 9	○ 10	○ 11	○ 12	○ 13
2. Dental concerns or issues	○ 1	○ CARelatedDental 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8	○ 9	○ 10	○ 11	○ 12	○ 13
3. Infection	○ 1	○ CARelatedInfection 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8	○ 9	○ 10	○ 11	○ 12	○ 13
4. Porta cath insertion or maintenance	○ 1	○ CARelatedPortaCath 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8	○ 9	○ 10	○ 11	○ 12	○ 13
5. IV therapy	○ 1	○ CARelatedIVTx 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8	○ 9	○ 10	○ 11	○ 12	○ 13
6. Pre-chemotherapy visit	○ 1	○ CARelatedPreChemo 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8	○ 9	○ 10	○ 11	○ 12	○ 13
7. Pre-radiation visit	○ 1	○ CARelatedPreRad 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8	○ 9	○ 10	○ 11	○ 12	○ 13
8. Post-operative recovery	○ 1	○ CARelatedPostOp 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8	○ 9	○ 10	○ 11	○ 12	○ 13
9. Radiation therapy	○ 1	○ CARelatedRadTx 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8	○ 9	○ 10	○ 11	○ 12	○ 13
10. Routine follow-up and examination	○ 1	○ CARelatedFU 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8	○ 9	○ 10	○ 11	○ 12	○ 13
11. Wound care	○ 1	○ CARelatedWound 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8	○ 9	○ 10	○ 11	○ 12	○ 13
12. Other, please specify: SKFICARelatedOther	○ 1	○ CARelatedOther 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8	○ 9	○ 10	○ 11	○ 12	○ 13

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Annotations modified: 3/2/2015

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Reason for using service	Hospital	ER	Surgeon	Oncologist	Primary Care Provider	Specialist	Skilled Nursing Facility	Visiting Nurse	Complemetary Therapies	Rehab	Counseling Services	Supportive Services	Other
CANCER-RELATED SYMPTOMS													
13. Bleeding	○ 1	○ CARelated2Bleeding	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8	○ 9	○ 10	○ 11	○ 12	○ 13
14. Bone loss	○ 1	○ CARelated2BoneLoss	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8	○ 9	○ 10	○ 11	○ 12	○ 13
15. Constipation	○ 1	○ CARelated2Constipation	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8	○ 9	○ 10	○ 11	○ 12	○ 13
16. Diarrhea	○ 1	○ CARelated2Diarrhea	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8	○ 9	○ 10	○ 11	○ 12	○ 13
17. Dizziness or weakness	○ 1	○ CARelated2Dizzy	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8	○ 9	○ 10	○ 11	○ 12	○ 13
18. Fever	○ 1	○ CARelated2Fever	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8	○ 9	○ 10	○ 11	○ 12	○ 13
19. Hearing loss	○ 1	○ CARelated2Hearing	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8	○ 9	○ 10	○ 11	○ 12	○ 13
20. Nausea or vomiting	○ 1	○ CARelated2Nausea	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8	○ 9	○ 10	○ 11	○ 12	○ 13
21. Numbness or tingling of hands or feet	○ 1	○ CARelated2Numb	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8	○ 9	○ 10	○ 11	○ 12	○ 13
22. Pain	○ 1	○ CARelated2Pain	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8	○ 9	○ 10	○ 11	○ 12	○ 13
23. Weight gain or swelling	○ 1	○ CARelated2Weight	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8	○ 9	○ 10	○ 11	○ 12	○ 13
24. Other, please specify: SKFICARelatedOtherSympt	○ 1	○ CARelated2OtherSympt	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8	○ 9	○ 10	○ 11	○ 12	○ 13

COHADM3027v00 Rev: 03/02/2015

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Annotations modified: 3/2/2015

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	1	2	3	4	5	6	7	8	9	10	11	12	13
Reason for using service	Hospital	ER	Surgeon	Oncologist	Primary Care Provider	Specialist	Skilled Nursing Facility	Visiting Nurse	Complementary Therapies	Rehab	Counseling Services	Supportive Services	Other
GENERAL REASONS OR HEALTH													
25. Chronic disease management (diabetes arthritis, high cholesterol, etc.)	○ 1	○ 2 GenRsnChronic	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8	○ 9	○ 10	○ 11	○ 12	○ 13
26. Feeding, bathing, and dressing	○ 1	○ 2 GenRsnFeed	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8	○ 9	○ 10	○ 11	○ 12	○ 13
27. Gastrointestinal issues	○ 1	○ 2 GenRsnGI	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8	○ 9	○ 10	○ 11	○ 12	○ 13
28. General Information	○ 1	○ 2 GenRsnGeneral	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8	○ 9	○ 10	○ 11	○ 12	○ 13
29. Heart, circulation or blood pressure issues	○ 1	○ 2 GenRsnHeart	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8	○ 9	○ 10	○ 11	○ 12	○ 13
30. Kidney or urinary issues	○ 1	○ 2 GenRsnKidney	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8	○ 9	○ 10	○ 11	○ 12	○ 13
31. Medication issues	○ 1	○ 2 GenRsnMed	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8	○ 9	○ 10	○ 11	○ 12	○ 13
32. Memory issues	○ 1	○ 2 GenRsnMemory	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8	○ 9	○ 10	○ 11	○ 12	○ 13
33. Parkinson's disease or other problems with motor function,	○ 1	○ 2 GenRsnParkinsons	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8	○ 9	○ 10	○ 11	○ 12	○ 13
34. Physical function (walking, climbing stairs, getting out of bed, using toilet)	○ 1	○ 2 GenRsnPhysical	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8	○ 9	○ 10	○ 11	○ 12	○ 13
35. Post-operative recovery	○ 1	○ 2 GenRsnPostOp	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8	○ 9	○ 10	○ 11	○ 12	○ 13
36. Pulmonary or breathing problems	○ 1	○ 2 GenRsnPulmonary	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8	○ 9	○ 10	○ 11	○ 12	○ 13

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Reason for using service	Hospital	ER	Surgeon	Oncologist	Primary Care Provider	Specialist	Skilled Nursing Facility	Visiting Nurse	Complementary Therapies	Rehab	Counseling Services	Supportive Services	Other
GENERAL REASONS OR HEALTH													
37. Referral needed for a specialist	○ 1	○ 2 GenRsnISpecialist	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8	○ 9	○ 10	○ 11	○ 12	○ 13
38. Smoking cessation	○ 1	○ 2 GenRsnSmoke	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8	○ 9	○ 10	○ 11	○ 12	○ 13
39. Substance abuse	○ 1	○ 2 GenRsnSubstance	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8	○ 9	○ 10	○ 11	○ 12	○ 13
40. Supply, install, monitor, teach use of, adaptive equipment in the home (e.g. oxygen)	○ 1	○ 2 GenRsnEquip	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8	○ 9	○ 10	○ 11	○ 12	○ 13
41. Swallowing difficulties	○ 1	○ 2 GenRsnSwallow	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8	○ 9	○ 10	○ 11	○ 12	○ 13
42. Swelling in arms, abdomen or legs	○ 1	○ 2 GenRsnSwelling	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8	○ 9	○ 10	○ 11	○ 12	○ 13
43. Transportation	○ 1	○ 2 GenRsnTransport	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8	○ 9	○ 10	○ 11	○ 12	○ 13
44. Unable to care for self at home	○ 1	○ 2 GenRsnSelfCare	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8	○ 9	○ 10	○ 11	○ 12	○ 13
45. Wound care	○ 1	○ 2 GenRsnWoundCare	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8	○ 9	○ 10	○ 11	○ 12	○ 13
46. Other, please specify: SKFIGenRsnOther	○ 1	○ 2 GenRsnOther	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8	○ 9	○ 10	○ 11	○ 12	○ 13

Report of Health Care Services

City of Hope

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Reason for using service	Hospital	ER	Surgeon	Oncologist	Primary Care Provider	Specialist	Skilled Nursing Facility	Visiting Nurse	Complementary Therapies	Rehab	Counseling Services	Supportive Services	Other
PSYCHOLOGICAL / MENTAL ISSUES													
47. Attention, memory, problem-solving and executive functions	○ 1	○ 2 PsychAttention	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8	○ 9	○ 10	○ 11	○ 12	○ 13
48. Family unable to adjust to illness	○ 1	○ 2 PsychAdjust	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8	○ 9	○ 10	○ 11	○ 12	○ 13
49. Irritability	○ 1	○ 2 PsychIrritable	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8	○ 9	○ 10	○ 11	○ 12	○ 13
50. Problems at work	○ 1	○ 2 PsychWork	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8	○ 9	○ 10	○ 11	○ 12	○ 13
51. Problems with appetite	○ 1	○ 2 PsychAppetite	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8	○ 9	○ 10	○ 11	○ 12	○ 13
52. Sadness, decreased mood, hopelessness	○ 1	○ 2 PsychHopelessness	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8	○ 9	○ 10	○ 11	○ 12	○ 13
53. Trouble sleeping	○ 1	○ 2 PsychSleep	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8	○ 9	○ 10	○ 11	○ 12	○ 13
54. Worry and uncertainty	○ 1	○ 2 PsychWorry	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8	○ 9	○ 10	○ 11	○ 12	○ 13
55. Other, please specify: SKEIPsychOther	○ 1	○ 2 PsychOther	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8	○ 9	○ 10	○ 11	○ 12	○ 13
MEDICAL RESOURCES													
56. American Cancer Society	○ 1	○ 2 MedResACS	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8	○ 9	○ 10	○ 11	○ 12	○ 13
57. Cancer Support Group	○ 1	○ 2 MedResCaSuppGrp	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8	○ 9	○ 10	○ 11	○ 12	○ 13

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Reason for using service	Hospital	ER	Surgeon	Oncologist	Primary Care Provider	Specialist	Skilled Nursing Facility	Visiting Nurse	Complementary Therapies	Rehab	Counseling Services	Supportive Services	Other
MEDICAL RESOURCES													
58. Human Resource Personnel	1	2 MedResHRPersonnel	3	4	5	6	7	8	9	10	11	12	13
59. Lance Armstrong Foundation	1	2 MedResArmstrong	3	4	5	6	7	8	9	10	11	12	13
60. Wellness Community Foundation	1	2 MedResWellness	3	4	5	6	7	8	9	10	11	12	13
61. Other, please specify: SKFMedResOther	1	2 MedResOther	3	4	5	6	7	8	9	10	11	12	13
GENERAL RESOURCES													
62. Childcare	1	2 GenResChildcare	3	4	5	6	7	8	9	10	11	12	13
63. Financial Planner	1	2 GenResFinPlan	3	4	5	6	7	8	9	10	11	12	13
64. Home Health Aide	1	2 GenResHomeAid	3	4	5	6	7	8	9	10	11	12	13
65. Housekeeper	1	2 GenResHouseKeeper	3	4	5	6	7	8	9	10	11	12	13
66. Lawyer	1	2 GenResLawyer	3	4	5	6	7	8	9	10	11	12	13
67. Religious/Spiritual	1	2 GenResReligious	3	4	5	6	7	8	9	10	11	12	13
68. Other, please specify: SKFIGenResOther	1	2 GenResOther	3	4	5	6	7	8	9	10	11	12	13

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Protocol ID:	Research Participant #:	Participant Initials:	Evaluation Code:
_____	_____	_____	_____

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If REHABILITATION SERVICE(S)/therapies were used, please specify the TYPE of services used:

Type of rehabilitation service used:	
Occupational therapy (RehabType)	○ 1
Physical therapy	○ 2
Respiratory therapy	○ 3
Speech therapy	○ 4

Finances and Out of Pocket Costs Tool

inTeleScans powered by Teleform

Protocol ID: ProtocolID

Research Participant #: RPN

Evaluation Code: EvaluationCode

Because this is a computer read form, please use **BLACK ink only.** Please solidly fill bubbles for choice responses.

Date of Form Completion: FormCompletionDate ___ / ___ / ____ (month / day / year)

General Questions

We are trying to understand how pancreatic cancer affects you and your family's finances after treatment. For this reason, I am going to ask you several questions about income, health insurance and out of pocket costs. The first group of questions asks about insurance. Please answer the questions based on your experience since you started treatment.

IncomeDecreaseYN

1. Has there been a decrease in your income level? 1 Yes 0 No 2 Does Not Apply

SpouseIncomeDecreaseYN

2. Has there been a decrease in your spouse/partner's income level? 1 Yes 0 No 2 Does Not Apply

InsuranceYN

3. Do you have health insurance? 1 Yes 0 No 2 Does Not Apply

4. What type of insurance do you have? 1 Private 4 Medicare 7 Medicaid

InsuranceType 2 HMO 5 PPO 8 POS

3 VA 6 Cobra 9 Other: SKFIInsuranceType _____

InsuranceCostIncreaseYN

5. Has the cost of your insurance premiums increased? 1 Yes 0 No 2 Does Not Apply

6. If yes, how much have the monthly premiums increased? $ InsuranceCost

BenefitExceedYN

7. Have you exceeded the amount for any covered benefits? 1 Yes 0 No 2 Does Not Apply

8. If yes, which benefits?

SKFIBenefitExceed

9. If your spouse/partner is currently employed, have they lost wages or salary or benefits due to caring for you

SpouseBenefitLoseYN

1 Yes 0 No 2 Does Not Apply

If you are currently employed: Over the last month, has your pancreatic cancer affected your...

10. Motivation to work? 1 Yes 0 No 2 Does Not Apply WorkMotivationYN

11. Productivity of work? 1 Yes 0 No 2 Does Not Apply WorkProductivityYN

12. Quality of your work? 1 Yes 0 No 2 Does Not Apply WorkQualityYN

13. Number of days missed from work? WorkDaysMissed

Protocol ID: _____ Research Participant #: _____ Evaluation Code: _____

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The next group of questions pertains to pancreatic cancer-related expenses: Since your diagnosis, have you, your relative or any family member spent out of pocket money on the following? (do not include money repaid to you by insurance):

14. Hospital bills?	HospitalBillYN 1 Yes 0 No	If yes, how much?	$ HospitalBill .
15. Doctor's bills?	DoctorBillYN 1 Yes 0 No	If yes, how much?	$ DoctorBill .
16. Medical supplies?	MedicalSuppliesYN 1 Yes 0 No	If yes, how much?	$ MedicalSupplies .
17. Emergency or urgent care?	EmergencyCareYN 1 Yes 0 No	If yes, how much?	$ EmergencyCare .
18. Travel to the hospital, clinic, or doctor's office for treatment?	ClinicalTripYN 1 Yes 0 No	If yes, how much?	$ ClinicalTrip .
19. Prescription medications?	PrescriptionYN 1 Yes 0 No	If yes, how much?	$ Prescription .
20. Over the counter medication?	OverTheCounterYN 1 Yes 0 No	If yes, how much?	$ OverTheCounter .
21. Family support and counseling?	FamilySupportYN 1 Yes 0 No	If yes, how much?	$ FamilySupport .
22. Alternative treatment such as massage, herbs, alternative healers?	AlternativeTreatmentYN 1 Yes 0 No	If yes, how much?	$ AlternativeTreatment .
23. Nutritional counseling?	NutritionCounselYN 1 Yes 0 No	If yes, how much?	$ NutritionCounsel .
24. Individual counseling and support?	IndividualSupportYN 1 Yes 0 No	If yes, how much?	$ IndividualSupport .
25. Genetic testing/counseling?	GeneticCounselYN 1 Yes 0 No	If yes, how much?	$ GeneticCounsel .
26. House cleaning/cooking?	HouseSupportYN 1 Yes 0 No	If yes, how much?	$ HouseSupport .
27. Additional home maintenance (yard work)?	HomeMaintenanceYN 1 Yes 0 No	If yes, how much?	$ HomeMaintenance .
28. Additional child care?	ChildCareYN 1 Yes 0 No	If yes, how much?	$ ChildCare .
29. Other expenses?	OtherExpenseYN 1 Yes 0 No	If yes, how much?	$ OtherExpense .

If yes, please specify: SKFIOtherExpense

Protocol ID: _____ Research Participant #: _____ Evaluation Code: _____

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Due to your pancreatic cancer diagnosis, have you had to do any of the following?

30. Apply for unemployment? UnemploymentYN 1 Yes 0 No
31. Borrow money? BorrowMoneyYN 1 Yes 0 No
32. Change economic lifestyle? LifestyleChangeYN 1 Yes 0 No
33. Declare bankruptcy? BankruptcyYN 1 Yes 0 No
34. Sacrifice other things (vacations, etc.)? OtherSacrificeYN 1 Yes 0 No
35. Sell a house or property? SellPropertyYN 1 Yes 0 No
36. Not pay bills on time? BillPayDelayYN 1 Yes 0 No
37. Take a second job? SecondJobYN 1 Yes 0 No
38. Use up savings? UseUpSavingsYN 1 Yes 0 No
39. Other actions? OtherActionsYN 1 Yes 0 No

If yes, please specify: SKFIOtherActions

40. Do you take medicines for any of the following conditions?

What is your out of pocket cost per month for these medicines?

Allergies	TxAllergiesYN 1 Yes 0 No	$ TxAllergies .
Angina (chest pain)	TxAnginaYN 1 Yes 0 No	$ TxAngina .
Asthma	TxAsthmaYN 1 Yes 0 No	$ TxAsthma .
Anxiety	TxAnxietyYN 1 Yes 0 No	$ TxAnxiety .
Bladder spasms	TxBladderSpasmsYN 1 Yes 0 No	$ TxBladderSpasms .
Cancer	TxCancerYN 1 Yes 0 No	$ TxCancer .
Congestive heart failure	TxHeartFailureYN 1 Yes 0 No	$ TxHeartFailure .
Cough	TxCoughYN 1 Yes 0 No	$ TxCough .
Depression	TxDepressionYN 1 Yes 0 No	$ TxDepression .
Diabetes	TxDiabetesYN 1 Yes 0 No	$ TxDiabetes .

Protocol ID: _____ Research Participant #: _____ Evaluation Code: _____

Because this is a computer read form, please use **BLACK ink only.** Please solidly fill bubbles for choice responses.

40. Do you take medicines for any of the following conditions? (continued)

What is your out of pocket cost per month for these medicines?

Edema/Swelling	TxEdemaYN: 1 Yes 0 No	$ TxEdema .
Heartburn	TxHeartburnYN: 1 Yes 0 No	$ TxHeartburn .
High cholesterol	TxHighCholesterolYN: 1 Yes 0 No	$ TxHighCholesterol .
High blood pressure	TxHighBPYN: 1 Yes 0 No	$ TxHighBP .
Hot flashes	TxHotFlashYN: 1 Yes 0 No	$ TxHotFlash .
Infections	TxInfectionYN: 1 Yes 0 No	$ TxInfection .
Insomnia/Sleep	TxInsomniaYN: 1 Yes 0 No	$ TxInsomnia .
Osteoporosis	TxOsteoporosisYN: 1 Yes 0 No	$ TxOsteoporosis .
Pain	TxPainYN: 1 Yes 0 No	$ TxPain .
Thyroid condition	TxThyroidConditionYN: 1 Yes 0 No	$ TxThyroidCondition .
Ulcers	TxUlcersYN: 1 Yes 0 No	$ TxUlcers .
Other, specify: _____	SKFITxOther1 / TxOther1YN: 1 Yes 0 No	$ TxOther1 .
Other, specify: _____	SKFITxOther2 / TxOther2YN: 1 Yes 0 No	$ TxOther2 .
Other, specify: _____	SKFITxOther3 / TxOther3YN: 1 Yes 0 No	$ TxOther3 .

41. Do you take any of the following types of over the counter medicines?

What is your out of pocket cost per month for these medicines?

Allergy	MedsAllergyYn: 1 Yes 0 No	$ MedsAllergy .
Cough	MedsCoughYN: 1 Yes 0 No	$ MedsCough .
Heartburn	MedsHeartBurnYN: 1 Yes 0 No	$ MedsHeartBurn .
Insomnia/Sleep	MedsInsomniaYN: 1 Yes 0 No	$ MedsInsomnia .
Laxatives	MedsLaxativesYN: 1 Yes 0 No	$ MedsLaxatives .

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Protocol ID: _____ Research Participant #: _____ Evaluation Code: _____

Because this is a computer read form, please use **BLACK ink only.** Please solidly fill bubbles for choice responses.

41. Do you take any of the following types of over the counter medicines? (continued)

What is your out of pocket cost per month for these medicines?

Pain	MedsPainYN: 1 Yes 0 No	$ MedsPain .
Vitamins	MedsVitaminsYN: 1 Yes 0 No	$ MedsVitamins .
Herbs	MedsHerbsYN: 1 Yes 0 No	$ MedsHerbs .
Amino Acids	MedsAminoAcidYN: 1 Yes 0 No	$ MedsAminoAcid .
Nutritional supplements	MedsNutriSupplementYN: 1 Yes 0 No	$ MedsNutriSupplement .
Other, specify: SKFIMedsOther1	MedsOther1YN: 1 Yes 0 No	$ MedsOther1 .
Other, specify: SKFIMedsOther2	MedsOther2YN: 1 Yes 0 No	$ MedsOther2 .
Other, specify: SKFIMedsOther3	MedsOther3YN: 1 Yes 0 No	$ MedsOther3 .

42. Do you have sick leave? SickLeaveYN: 1 Yes 0 No

43. How many days per year? SickDays

44. Do you have paid sick leave if you visit a doctor? PaidSickLeaveYN: 1 Yes 0 No

44a. Go for tests and procedures? PaidClinicalTestYN: 1 Yes 0 No

Personal costs associated with the intervention

1. In the past month, how much time did you spend reading the education materials?

   Hours EducationMaterialHr Minutes EducationMaterialMin

2. How much time did you spend reading your care plan?

   Hours CarePlanHr Minutes CarePlanMin

3. How many cell phone minutes did it cost you to participate in the two teaching sessions?

   Minutes CellPhoneMin

4. How much time did you spend contacting the research nurse outside of the two teaching sessions?

   Hours ContactTimeHr Minutes ContactTimeMin

Protocol ID: _____ Research Participant #: _____ Evaluation Code: _____

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TelephoneCostYN

5. Did you incur additional telephone costs? 1 Yes 0 No

5a. If yes, how much did it cost? $ TelephoneCost

AdditionalPocketCostYN

6. Have you incurred any additional out of pocket costs to participate in the study intervention? 1 Yes 0 No

6a. If yes, can you explain?

SKFIAdditionalPocketCost

Patient Satisfaction with Intervention Tool

inTeleScans powered by Teleform

Protocol ID: ProtocolID

Research Participant # RPN

Evaluation Code EvaluationCode

Because this is a computer read form, please use **BLACK ink only.** Please solidly fill bubbles for choice responses.

Date of Form Completion: FormCompletionDate (month / day / year)

Patient Satisfaction with Intervention Tool

	(Please Select One Bubble Per Line)				
	Poor	Fair	Good	Very Good	Excellent
Thinking about the intervention that you received, how would you rate the following?					
1. Overall how would you rate the intervention?	RateIntervention 0	1	2	3	4
2. Availability of nurse by phone	NurseAvailability 0	1	2	3	4
3. Referral to supportive care services	SupportCareServices 0	1	2	3	4
4. Thoroughness of care provided through intervention	ThoroughnessOfCare 0	1	2	3	4
5. Skill and experience of intervention nurse	SkillandExperience 0	1	2	3	4
6. Explanation of physical symptoms	ExplanationPhysicalSymps 0	1	2	3	4
7. Explanation of psychological symptoms	ExplanationPsychologicalSymps 0	1	2	3	4
8. Explanation of social well-being concerns	ExplanationSocialWellBeing 0	1	2	3	4
9. Explanation of spiritual well-being concerns	ExplanationSpiritualWellBeing 0	1	2	3	4

For questions 10, 11 and 12: Select only one option per question.

AmountInfoHandbookCare

10. Was the amount of information in the handbook? 1 Too little 2 The right amount 3 Too much

Time_spent_handbook

11. Was the time spent going over the care plan and handbook? 1 Too short 2 The right amount 3 Too long

12. How effective was the Reseal ResNurseEffective he care plan and handbook with you?

Not effective at all 1 0 2 1 3 2 4 3 5 4 Extremely effective

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0 0 0 1

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Annotations modified: 1/15/2015

CarBITS.dbo.NursePatientSatisfactionInter (vNursePatientSatisfactionInter)

Protocol # _____ Research Participant # _____ Evaluation Code _____

Because this is a computer read form, please use **BLACK ink only.** Please solidly fill bubbles for choice responses.

PCPI Intervention: Exit Interview

Teaching session

13. Did you receive enough teaching from the two sessions?

TeachingSession

14. How could the teaching be improved?

ImprovTeaching

Materials

15. Were the teaching materials adequate?

MaterialAdequate

16. How could the materials be improved?

MaterialsImprov

17. Did you have any problems with the language?

ProblemLanguage

0 0 0 1

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Annotations modified: 1/15/2015

CarBITS.dbo.NursePatientSatisfactionInter (vNursePatientSatisfactionInter)

Protocol # _____ Research Participant # _____ Evaluation Code _____

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PCPI Intervention Program

18. What were the strengths of the program?

ProgStrengths

19. What were the weaknesses of this program?

ProWeakness

20. What improvements would you recommend?

RecImprove

0 0 0 1

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Annotations modified: 1/15/2015

CarBITS.dbo.NursePatientSatisfactionInter (vNursePatientSatisfactionInter)

FACIT-Sp-12 (Version 4)

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Protocol ID: ProtocolID

Research Participant # RPN

Evaluation Code EvaluationCode

Because this is a computer read form, please use **BLACK ink only.** Please solidly fill bubbles for choice responses.

Below is a list of statements that other people with your illness have said are important. Please select one bubble per line to indicate your response as it applies to the **past 7 days**.

	Not at all	A little bit	Some-what	Quite a bit	Very much
1. I feel peaceful	FeelPeaceful 0	1	2	3	4
2. I have a reason for living	ReasonForLiving 0	1	2	3	4
3. My life has been productive	LifeProductive 0	1	2	3	4
4. I have trouble feeling peace of mind	PeaceOfMind 0	1	2	3	4
5. I feel a sense of purpose in my life	PurposeInLife 0	1	2	3	4
6. I am able to reach down deep into myself for comfort	MyselfForComfort 0	1	2	3	4
7. I feel a sense of harmony within myself	HarmonyWithinSelf 0	1	2	3	4
8. My life lacks meaning and purpose	LifeLacksMeaningAndPurpose 0	1	2	3	4
9. I find comfort in my faith or spiritual beliefs	ComfortInFaith 0	1	2	3	4
10. I find strength in my faith or spiritual beliefs	StrengthInFaith 0	1	2	3	4
11. My illness has strengthened my faith or spiritual beliefs	IllnessStrenghenedMyFaith 0	1	2	3	4
12. I know that whatever happens with my illness, things will be okay	ThingsWillBeOkay 0	1	2	3	4

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COHADM3030v00 rev: 01/13/2015

Annotations modified: 1/13/2015

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