REDUCING END-of-LIFE SYMPTOMS WITH TOUCH (REST)	
Screening	**FORM 01**

Instructions:

This form does NOT need to be completed UNLESS a patient meets BOTH Phase I AND Phase II eligibility criteria. If the patient meets ALL of these criteria, please transfer the information to Page 2 of the form and proceed to the Phase III Eligibility Screening (patient interview) on Page 3.

The On-Site Study Coordinator (OSSC) should complete this form at the time each patient is screened for Phase III Eligibility. After the screening process is complete, the OSSC should return the form as soon as possible to the PoPCRN Office in one of the business reply envelopes supplied for the study.

If the screened patient was enrolled in the study, then please do the following:

1) Complete questions 5-17 by consulting medical records and/or staff
2) Ensure that all questions have been answered on each page or 'unavailable' has been written next to them
3) Remove the pink copies and retain them in the patient's file
4) Make copies of the Consent and HIPAA Authorization B Forms for the patient's file (recommended)
5) Mail the blue enrollment packet along with the original, signed copies of the Consent and HIPAA Authorization B Forms to the PoPCRN Office

If the screened patient was found to be ineligible for or decides not to enroll in the study, then please do the following:

1) Complete questions 4a-4e2 (based on where the patient interview ended) and questions 6, 7, 8, 9, 11 & 14 by consulting medical records and/or staff
2) Scribble out the patients initials on each page to ensure they are illegible (if applicable)
3) Remove the pink copies and retain them in the patient's file
4) Remove the form from the blue enrollment packet (if applicable)
5) Paper clip all pages of the form together
6) Mail the form to the PoPCRN Office

REDUCING END-of-LIFE SYMPTOMS WITH TOUCH (REST)

Screening	FORM 01

Instructions: *This form does **NOT** need to be completed **UNLESS** a patient meets **BOTH** Phase I **AND** Phase II eligibility criteria. If the patient meets **ALL** of these criteria, please transfer the information to Page 2 of the form and proceed to the Phase III Eligibility Screening (patient interview) on Page 3. The On-Site Study Coordinator (OSSC) should complete this form at the time each patient is screened for Phase III Eligibility. After the screening process is complete, the OSSC should return the form as soon as possible to the PoPCRN Office in one of the business reply envelopes supplied for the study.*

Patient ID: 1-5 [ ][ ] - [ ][ ][ ] **[subject]** **Patient Initials:** 6-8 [ ][ ][ ]

Visit No: 9 [0] **[visit]**

Form No: 10-11 [0][1] **[form]**

1. Date: 12-19 [ ][ ] MM [ ][ ] DD [ ][ ][ ][ ] Year

2. **Phase I Eligibility Screening:** *(Instructions - Please attempt to obtain this information from the medical records or medical staff first. If unable to do so, please ask the patient during the Phase III patient interview on Page 3. Please mark the answers to the questions below and on other pages of this form as indicated.)*

		Yes	No
a.	Adult age (>=18 years) *[See **Question 7 on Page 3**]*: **[over18]**	20 [1]	[0]
b.	English speaking: **[english]**	21 [1]	[0]
c.	Anticipated life expectancy of at least 3 weeks: **[lifeExpectancy]**	22 [1]	[0]
d.	Advanced cancer diagnosis *[See **Question 14 on Page 4**]*:	23 [1]	[0]

*If ALL of the answers to the criteria above are **YES**, please proceed.*

*If ANY of the answers are **NO**, the patient is ineligible for the study. Do not proceed to the Phase II or III Eligibility Screening. Please attempt to obtain information for Questions 6, 7, 8, 9, 11 & 14 on this form through medical records and/or staff. Please send the completed form as soon as possible to the PoPCRN Office in one of the business reply envelopes supplied for the study.*
(Please refer to the instructions on Page 1 with regard to completing this form for ineligible patients.)

3. **Phase II Eligibility Screening:** *(Instructions - Please attempt to obtain this information from the medical records or medical staff first. If unable to do so, please ask the patient during the Phase III patient interview on Page 3. Please mark the answers to the questions below and on other pages of this form as indicated.)*

		Yes	No	Unavailable
a.	Patient is receiving anticoagulant (blood thinning) therapy: **[anticoag]**	24 [1]	[0]	[8]
b.	Patient has a known platelet count of <10,000: **[lowPlatelet]**	25 [1]	[0]	[8]
c.	Patient has a known unstable spine: **[unstableSpine]**	26 [1]	[0]	[8]

*If ALL of the answers to the criteria above are **NO** or **UNAVAILABLE**, please proceed.*

*If ANY of the answers are **YES**, the patient is ineligible for the study. Do not proceed to Phase III Eligibility Screening. Please attempt to obtain information for Questions 6, 7, 8, 9, 11 & 14 on this form through medical records and/or staff. Please send the completed form as soon as possible to the PoPCRN Office in one of the business reply envelopes supplied for the study.*
(Please refer to the instructions on Page 1 for completing this form for ineligible patients.)

REDUCING END-of-LIFE SYMPTOMS WITH TOUCH (REST)

Screening	FORM 01

Patient ID: 1-5 [ ][ ]-[ ][ ][ ] [subject] Patient Initials: 6-8 [ ][ ][ ] Visit No: 9 [0] [visit] Form No: 10-11 [0][1] [form]

4. **Phase III Eligibility Screening:** *(Instructions - This section involves the PATIENT INTERVIEW.)*

		Yes	No
a.	Patient has had professional massage therapy within the past 4 weeks: [past4wkMT] *(Ask **Questions 18a & 18b on Page 6** and mark responses on Pgs 6 & 3)*	27 [1]	[0]

If answer to 4a is "YES," patient is ineligible for this study. Please see instructions below in the gray box.

b.	Patient experiencing at least moderate pain within the past week (4 or more on 0-10 scale based on answers to ***Questions 19a & 19e***): (*Ask **Question 19 on Page 7** and mark responses on Pages 7 and 3)* [modPain]	28 [1]	[0]

If answer to 4b is "NO," patient is ineligible for this study. Please see instructions below in the gray box.

c.	Patient is able to participate in the study based on the SPMSQ with < 5 errors: (*Ask **Question 22a on Page 8,** the Short Portable Mental Status Questionnaire)* [eligSPMSQ]	29 [1]	[0]
d1.	Patient has agreed to be in this study, indicated their understanding of the study, and signed the Consent Form: [willing]	30 [1]	[0]

d2. If the patient did not consent and provided a reason, please specify:

_____

e1.	Patient has agreed to be in this study and signed the HIPAA Authorization Form B: [hipaaB]	31 [1]	[0]

e2. If the patient did not give authorization and provided a reason, please specify:

_____

*If the following are **TRUE,** the patient is eligible for this study.*
Answers to Question 4 are as follows:
Q. 4a: No
Q. 4b: Yes
Q. 4c: Yes
Q. 4d1: Yes
Q. 4e1: Yes
Please proceed to the randomization process. (See Form 02: Randomization Request)
*If the preceding are **NOT TRUE**, the patient is ineligible for this study. Please attempt to obtain the information for Questions 6, 7, 8, 9, 11 & 14 on this form through medical records and/or staff. Please send the completed form as soon as possible to the PoPCRN Office in one of the business reply envelopes supplied for the study.*
(Please refer to the instructions on Page 1 for completing this form for ineligible patients.)

5. Date patient enrolled with your organization: 32-39 [ ][ ] MM [ ][ ] DD [ ][ ][ ][ ] Year

Removed due to PHI, please see var [daysEnrollScreen] for number of days between org enrollment and screening

6. Gender: 40 [1] Male [2] Female [gender]

7. Year of Birth: 41-44 [ ][ ][ ][ ] Year

Removed due to PHI, please see var [age] for participant's age at randomization

REDUCING END-of-LIFE SYMPTOMS WITH TOUCH (REST)

Screening | FORM 01

Patient ID: 1-5 [ ][ ]-[ ][ ][ ] Patient Initials: 6-8 [ ][ ][ ] Visit No: 9 [0] [visit] Form No: 10-11 [0][1] [form]

[subject]

---

8. Race and Ethnic Background:

Ethnicity: *(Mark Yes or No for each)*

	Yes	No
[yesLatinx] a. Hispanic or Latino origin:	45 1	0
[noLatinx] b. Not of Hispanic or Latino origin:	46 1	0

9. **Race** *(Mark Yes or No for each)*

	Yes	No
a. White: [white]	47 1	0
b. Black or African American: [black]	48 1	0
c. Asian: [asian]	49 1	0
[pacific] d. Native Hawaiian or other Pacific Islander:	50 1	0
[aian] e. American Indian or Alaskan Native:	51 1	0
f. Other, please specify:_____	52 1	0

[otherRace]

10. Marital Status: *(Write Number in box)* 53 [ ] [marital]
1 = Married
2 = Committed Relationship
3 = Single, Never Married
4 = Divorced/Separated
5 = Widowed

11. Patient location: *(Write Number in box)* 54 [ ] [ploc]
1 = Home
2 = Nursing Home/Skilled Nursing Facility
3 = Hospice Facility
4 = Other, specify:_____

12. Patient's primary payor/insurance source: *(Write Number in box)* 55 [ ] [insurance]
1 = Medicare
2 = Medicaid
3 = Commercial (private) insurance
4 = Own income, family support
5 = Medically indigent
6 = Other, specify:_____

13. Education - Highest Grade Completed: *(Write Number in box)* 56 [ ] [education]
0 = No Education
1 = Grammar School
2 = High School
3 = College
4 = Postgraduate

14. Primary Active Advanced Cancer Type: 57-58 [ ][ ] *(Select from list below)* [priCa]

01 = Bladder
02 = Brain
03 = Breast
04 = Colorectal
05 = Kidney
06 = Leukemia
07 = Liver
08 = Lung
09 = Lymphoma
10 = Melanoma
11 = Multiple Myeloma
12 = Oropharyngeal
13 = Ovary
14 = Pancreas
15 = Prostate
16 = Skin (not melanoma)
17 = Stomach
18 = Uterus
19 = Other specify:_____
20 = Esophageal
21 = Unknown (ONLY if primary active type not known)

15. Date of initial cancer diagnosis: 59-64 [ ][ ] MM [ ][ ][ ][ ] Year

Removed due to PHI, please see var [yearsCaDx] or [monthsCaDx] for time between diagnosis and org enrollment

REDUCING END-of-LIFE SYMPTOMS WITH TOUCH (REST)

SCREENING (FORM 01)

Patient ID: 1-5 [ ][ ]-[ ][ ][ ] [subject] Patient Initials: 6-8 [ ][ ][ ] Visit No: 9 [0] [visit] Form No: 10-11 [0][1] [form]

16. Location of metastases *(Mark all Yes or No):*

		Yes	No	
a.	Bone:	65 [1]	[0]	[boneMet]
b.	Brain:	66 [1]	[0]	[brainMet]
c.	Liver:	67 [1]	[0]	[liverMet]
d.	Lung:	68 [1]	[0]	[lungMet]
e.	Spinal Cord:	69 [1]	[0]	[spinalMet]
f.	Other, specify:	70 [1]	[0]	[otherMet]
g.	None Known:	71 [1]	[0]	[noMet]
h.	Unknown:	72 [1]	[0]	[unknownMet]

17. Other major diagnoses for this patient are: *(Mark Yes or No for each): [From the medical records and/or patient interview]*

		Yes	No
a.	Arthritis: [arthritis]	73 [1]	[0]
b.	Additional Cancer diagnosis: [addCaDx]	74 [1]	[0]
c.	Deep venous thrombosis: [dvt]	75 [1]	[0]
d.	Delirium: [delirium]	76 [1]	[0]
e.	Dementia: [dementia]	77 [1]	[0]
f.	Depression: [depression]	78 [1]	[0]
g.	Diabetes: [diabetes]	79 [1]	[0]
h.	Global decline/frailty/failure to thrive: [globalDecline]	80 [1]	[0]
[heartDz] i.	Heart disease (e.g. congestive heart failure, coronary artery disease, atrial fibrillation):	81 [1]	[0]
j.	HIV/AIDS: [hiv]	82 [1]	[0]
k.	Hypertension: [htn]	83 [1]	[0]
l.	Infection (pneumonia, urinary tract infection, cellulitis): [infection]	84 [1]	[0]
m.	Kidney/renal disease: [renalDz]	85 [1]	[0]
n.	Liver disease: [liverDz]	86 [1]	[0]
[lungDz] o.	Lung disease (e.g. COPD, asthma, interstitial lung disease, pulmonary hypertension):	87 [1]	[0]

17. ***CONTINUED -*** Other major diagnoses for this patient are: *(Mark Yes or No for each): [From the medical records and/or patient interview]*

		Yes	No
p.	Neurologic disease (e.g. Parkinson's, ALS, multiple sclerosis): **[neuroDz]** 88	1	0
q.	Peripheral Vascular Disease: **[pvd]** 89	1	0
r.	Pressure ulcers: **[pressureUlcers]** 90	1	0
s.	Pulmonary embolus: **[pe]** 91	1	0
t.	Stroke: **[stroke]** 92	1	0
u.	Other (specify): _____ 93 **[otherDz]**	1	0

PATIENT INTERVIEW SECTION: *(INSTRUCTIONS: PLEASE ASK THE PATIENT TO ANSWER THE FOLLOWING QUESTIONS. PROVIDE THE PATIENT WITH THE RESPONSE CARDS FOR REFERENCE DURING THE INTERVIEW.)*

	Yes	No	Don't Know
18a. Have you (the patient) ever received professional massage therapy? *(Mark one)* **[pastMT]** 94	1	0	8

18b. *If YES, when was your most recent professional massage therapy session? (Mark one)* **[recentMT]**

95
- 1 Within the past 4 weeks
- 2 5 - 12 weeks ago
- 3 >12 weeks ago
- 4 Don't know
- 9 N/A

REDUCING END-of-LIFE SYMPTOMS WITH TOUCH (REST)

Screening	FORM 01

Patient ID: 1-5 [ ][ ]-[ ][ ][ ] [subject] Patient Initials: 6-8 [ ][ ][ ] Visit No: 9 [0] [visit] Form No: 10-11 [0][1] [form]

19. **PAIN SCREENING / ASSESSMENT TOOL**

a. Have you experienced pain, discomfort, or soreness at rest or with movement now or in the past week? *(Mark Yes or No)* [painPastWk] 96 [1] Yes [0] No

If the patient reports no pain, the interview is complete. PLEASE STOP HERE. The patient is NOT eligible for the study. If the patient reports pain, continue with the questions below.

CONTINUE *ONLY* IF PATIENT HAS PAIN

How strong is your pain? Because I can't feel your pain, I want you to use a scale *(show patient Pain Scale on Response Card #1 for this question)* to let me know how much pain you have. The numbers between 0 and 10 represent ALL the pain a person could have. Zero means "no pain" and 10 means "pain as bad as it could be." You can use ANY number between 0 and 10 to let me know how much pain you have. Call your pain a number between 0 and 10 so I will know the intensity of the pain you feel now.

Pain Intensity on Number Scale 0 - 10

(Record a number between 0-10 for each item, based on the patient's indication of his/her answer on the pain scale on Response Card #1.)

b. 97-98 [ ][ ] **now** [painNow]

c. 99-100 [ ][ ] **worst over past 24-hours** [painWorst24]

d. 101-102 [ ][ ] **least over past 24-hours** [painLeast24]

e. 103-104 [ ][ ] **worst over past week** [painWorstWk]

f. 105-106 [ ][ ] **least over past week** [painLeastWk]

g. 107-108 [ ][ ] **number you would *like* your pain to be** [painGoal]

20. How does your pain change with time? Which words would you use to describe the pattern of your pain? *(Mark all Yes or No):*

		Yes	No	
a.	Brief: — — — — — — — — — — — — — 109	1	0	[painBrief]
b.	Constant: — — — — — — — — — — — — 110	1	0	[painConstant]
c.	Intermittent (comes and goes): — — — — 111	1	0	[painIntermit]

21. On a 1 to 5 scale, where 1 is "not at all helpful" and 5 is "very helpful," how helpful do you believe massage therapy would be for your pain? *(Write answer in the box):*

112 ____ [MTefficacy]

1 = not at all helpful
2 = a little bit helpful
3 = somewhat helpful
4 = quite a bit helpful
5 = very helpful

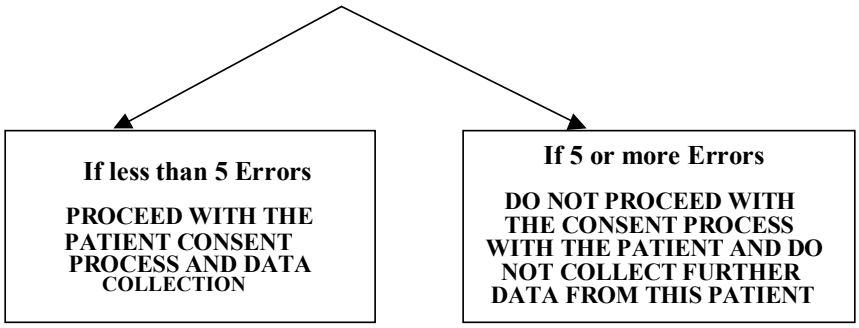
Instructions: *Ask questions 1-10 in this list, record all answers and check either "correct" or "error." An answer must be entirely correct for a "correct" score (e.g., Date: if month and year are correct but day is wrong, the score is "error"). Ask question 4a ONLY if patient does not have a telephone. Record total number of errors based on ten questions at the bottom of this page. If the patient's number of errors is only one digit, please enter zero in the first box,e.g., one error should be entered as "01." Total number of errors determines whether or not to approach the patient for informed consent for study participation.*

22a. Short Portable Mental Status Questionnaire (SPMSQ)

Correct	Error			
			1	**What is the date today?** ____/____/____ Month Day Year
			2	**What day of the week is it?** ____
			3	**What is the name of this place?** ____
			4	**What is your telephone number?** (____) - ____-____
			4a	**What is your street address?** ____ *(Ask only if patient does not have a phone)*
			5	**How old are you:** ____
			6	**When were you born?** ____
			7	**Who is currently the President of the U.S.?** ____
			8	**Who was President just before him?** ____
			9	**What was your mother's maiden name?** ____
			10	**Substract 3 from 20 and keep subtracting 3 from each new number, all the way down.** *(20,17,14,11,8,5,2)*
[errorSPMSQ]				**Total Number of Errors** 113-114 ____ *If total number of errors is ≥ 5, patient is ineligible for the study.*

Instructions: Proceed to next page.

Total Number of Errors on the Mental Status Questionnaire (page 8):



22b.Is this patient eligible to consent for this study? 115 [1] Yes [0] No

[eligible]

If YES, please proceed with the consent and authorization process. The Consent Form and HIPAA Authorization Form B are included in blue enrollment packets.

Form Completed By:_____

REDUCING END-of-LIFE SYMPTOMS WITH TOUCH (REST)

Randomization Request | FORM 02

Instructions: *The On-Site Study Coordinator (OSSC) should complete this form to request randomization to one of the treatment arms for each patient enrolled in the study. The OSSC should only complete the form* ***AFTER*** *the patient has signed the Consent and HIPAA Forms and the patient's signatures have been verified.*

If the enrollment process took place via telephone interview, the OSSC or On-Site Data Collector (OSDC) ***MUST*** *physically verify that the Consent and HIPAA Forms have been signed by the patient* ***BEFORE*** *a Randomization Request is made with this form or the Baseline Data Collection (Visit #1) is conducted.*

Please fax this document to the PoPCRN Office using the toll-free number listed below.

Patient ID: 1-5 [ ][ ]-[ ][ ][ ] **[subject]** **Patient Initials:** 6-8 [ ][ ][ ] **Visit No:** 9 [0] **Form No:** 10-11 [0][2]

Instructions: Complete Questions 1-3 and fax the form to the PoPCRN Office at ***1-866-301-7268***

1. Date of Randomization Request: 12-19 [ ][ ] MM [ ][ ] DD [ ][ ][ ][ ] Year

Removed due to PHI, please see var [daysScreenRand] for number of days between screening and randomization or [daysOrgEnrollRand] for number of days between hospice organization enrollment and screening

	Yes	No
2. Patient met eligibility requirements for study?	20 [1]	[2]
3. Patient signed Consent Form and HIPAA Authorization Form B?	21 [1]	[2]

Instructions: Complete Question 4 after receiving randomization assignment from the PoPCRN Office

	Moving Touch	Non-Moving Touch
4. Record randomized treatment group for this patient based on email or phone call from PoPCRN Office. **[groupCode]**	22 [1]	[2]

Form Completed By:_____

REDUCING END-of-LIFE SYMPTOMS WITH TOUCH (REST)

Neuropathy Pain Scale (NPS) | FORM 03

Instructions: *The On-Site Data Collector (OSDC) should complete this form for each patient ONLY at the Baseline Data Collection (Visit #1). The Baseline Data Collection can occur before Randomization Assignment OR within 3 working days of the Enrollment Date. If the Baseline Data Collection occurs after Randomization Assignment, then the the On-Site Study Coordinator (OSSC) will contact the OSDC regarding the Enrollment Date.*

Patient ID: 1-5 ☐☐-☐☐☐ **[subject]** | **Patient Initials:** 6-8 ☐☐☐ | **Visit No:** 9 1 **[visit]** | **Form No:** 10-11 0 3 **[form]**

1. Date: 12-19 ☐☐ MM ☐☐ DD ☐☐☐☐ Year

Removed due to PHI, please see var [daysRandNPS] for number of days between randomization and this form.

2. Patient location: **[ploc]** *(Write Number in box)* 20 ☐
   1 = Home
   2 = Nursing Home/Skilled Nursing Facility
   3 = Hospice Facility
   4 = Other, specify:_____

Instructions: Please show the patient Response Card #2 and record the number indicated by the patient in the box beside each scale. If the patient's response is less than 2 digits, please place a zero in the first box.

3. **Neuropathy Pain Scale**:

a. Please use the scale shown on the card to tell us how **intense** your pain is. Which number best describes the intensity of your pain.

0 (No Pain) 1 2 3 4 5 6 7 8 9 10 (The most **intense** pain sensation imaginable)

21-22 ☐☐ **[npsIntense]**

b. Please use the scale shown on the card to tell us how **sharp** your pain feels. Words used to describe "sharp" feelings include "like a knife", "like a spike", "jabbing" or "like jolts".

0 (Not sharp) 1 2 3 4 5 6 7 8 9 10 (The most **sharp** sensation imaginable ("like a knife"))

23-24 ☐☐ **[npsSharp]**

c. Please use the scale shown on the card to tell us how **hot** your pain feels. Words used to describe very hot pain include "burning" and "on fire".

0 (Not hot) 1 2 3 4 5 6 7 8 9 10 (The most **hot** sensation imaginable ("on fire"))

25-26 ☐☐ **[npsHot]**

d. Please use the scale shown on the card to tell us how **dull** your pain feels. Words used to describe very dull pain include "like a dull toothache", "dull pain", "aching" and "like a bruise".

0 (Not dull) 1 2 3 4 5 6 7 8 9 10 (The most **dull** sensation imaginable)

27-28 ☐☐ **[npsDull]**

e. Please use the scale shown on the card to tell us how **cold** your pain feels. Words used to describe very cold pain include "like ice" and "freezing".

0 (Not cold) 1 2 3 4 5 6 7 8 9 10 (The most **cold** sensation imaginable ("freezing"))

29-30 ☐☐ **[npsCold]**

REDUCING END-of-LIFE SYMPTOMS WITH TOUCH (REST)

Neuropathy Pain Scale (NPS) | FORM 03

Patient ID: 1-5 [ ][ ]-[ ][ ][ ] **[subject]** **Patient Initials:** 6-8 [ ][ ][ ] **Visit No:** 9 [1] **[visit]** **Form No:** 10-11 [0][3] **[form]**

f. Please use the scale shown on the card to tell us how **sensitive** your skin is to light touch or clothing. Words used to describe sensitive skin include "like sunburned skin" and "raw skin".

0 (Not sensitive) 1 2 3 4 5 6 7 8 9 10 (The most **sensitive** sensation imaginable ("raw skin"))

31-32 [ ][ ] **[npsSens]**

g. Please use the scale shown on the card to tell us how **itchy** your pain feels. Words used to describe itchy pain include "like poison oak" and "like a mosquito bite".

0 (Not itchy) 1 2 3 4 5 6 7 8 9 10 (The most **itchy** sensation imaginable ("like poison oak"))

33-34 [ ][ ] **[npsItch]**

h. Which of the following best describes the **time** quality of your pain? *Please complete only one answer:*

[npsTime] 35 [ ]

1 = I feel a background pain all of the time **and** occasional flare-ups (breakthrough pain) some of the time.
2 = I feel a single type of pain all of the time.
3 = I feel a single type of pain only sometimes. Other times I am pain-free.

i. Now that you have told us the different physical aspects of your pain, the different types of sensations, we want you to tell us overall how **unpleasant** your pain is to you. Words used to describe very unpleasant pain include "miserable" and "intolerable". Remember, pain can have a low intensity, but still feel extremely unpleasant, and some kinds of pain can have a high intensity but be very tolerable. With the scale shown on the card, please tell us how **unpleasant** your pain feels.

0 (Not unpleasant) 1 2 3 4 5 6 7 8 9 10 (The most **unpleasant** sensation imaginable ("intolerable"))

36-37 [ ][ ] **[npsUnpleas]**

Lastly, we want you to give us an estimate of the severity of your deep versus surface pain. We want you to rate each type of pain separately. We realize that it can be difficult to make these estimates, and most likely it will be a "best guess", but please give us your best estimate.

j. How intense is your deep pain?

0 (No deep pain) 1 2 3 4 5 6 7 8 9 10 (The most **intense deep** pain sensation imaginable)

38-39 [ ][ ] **[npsDeep]**

k. How intense is your surface pain?

0 (No surface pain) 1 2 3 4 5 6 7 8 9 10 (The most **intense surface** pain sensation imaginable)

40-41 [ ][ ] **[npsSurface]**

Form Completed by:_____

REDUCING END-of-LIFE SYMPTOMS WITH TOUCH (REST)

Pain Evaluation | FORM 04

Instructions: *The On-Site Data Collector (OSDC) should complete this form for each patient at approximately weekly intervals.*
The Data Collection Visits should be scheduled as follows:
Baseline Data Collection (Visit #1)--Must occur within 3 working days of enrollment (signing of Consent and HIPAA Forms)
1st Weekly Visit (Visit #2)--Must occur approximately 5 working days from the Baseline Data Collection
2nd Weekly Visit (Visit #3)--Must occur approximately 5 working days from the 1st Weekly Visit (Visit #2)
Final Visit (Visit #4)--Must occur approximately 7 working days following the Final Treatment Visit [Note: For more information about the Final Visit, please refer to Section II, Part D (OSDC) or the instructions for Forms SC-3a-3e in Section III, Part A (OSSTM Forms) of the manual.]

Patient ID: 1-5 ____-____ [subject] **Patient Initials:** 6-8 ___ **Visit No:** 9 ___ (1 = Visit 1 (baseline), 2 = Visit 2, 3 = Visit 3, 4 = Visit 4 (final)) [visit] **Form No:** 10-11 0 4 [form]

1. Date: 12-19 MM DD Year **2. Patient location:** (Write Number in box) 20 ___
1 = Home
2 = Nursing Home/Skilled Nursing Facility
3 = Hospice Facility
4 = Other, specify:_____ [ploc]

Removed due to PHI, please see var [daysRandPainEval] for number of days between randomization and this form's date

Instructions: Please ask the patient to indicate on the Body Diagram on Response Card #3 where he/she is experiencing pain. For those areas where the patient is experiencing pain, please ask him/her to indicate on the 0-10 scale how much pain he/she is experiencing [0 *(no pain)* ***to 10*** *(pain as bad as it could be)]***.**

3. Where is your pain? (*Mark Yes or No* in the list where the patient has indicated areas of pain. For those areas where the patient is experiencing pain, *record the level of pain 01-10.*)
Please note: 'a' = Right side of the body; 'b' = Left side of the body

Body Section	YES	NO	If YES, level of pain (01-10)
1. Face [ynFace]	21 1	0	22-23 [lvFace]
2. Chest [ynChest]	24 1	0	25-26 [lvChest]
3a. Upper Arm - R (front & back) [ynArmUpR]	27 1	0	28-29 [lvArmUpR]
3b. Upper Arm - L (front & back) [ynArmUpL]	30 1	0	31-32 [lvArmUpL]
4a. Lower Arm - R (front & back) [ynArmLowR]	33 1	0	34-35 [lvArmLowR]
4b. Lower Arm - L (front & back) [ynArmLowL]	36 1	0	37-38 [lvArmLowL]
5a. Palm of Hand - R [ynPalmR]	39 1	0	40-41 [lvPalmR]
5b. Palm of Hand - L [ynPalmL]	42 1	0	43-44 [lvPalmL]
6. Abdomen [ynAbdomen]	45 1	0	46-47 [lvAbdomen]
7a. Front of Upper Leg - R [ynLegFrontUpR]	48 1	0	49-50 [lvLegFrontUpR]

REDUCING END-of-LIFE SYMPTOMS WITH TOUCH (REST)

Pain Evaluation | FORM 04

Patient ID: 1-5 [subject] Patient Initials: 6-8 Visit No: 9 (1 = Visit 1 (baseline), 2 = Visit 2, 3 = Visit 3, 4 = Visit 4 (final)) [visit] Form No: 10-11 0 4 [form]

Body Section	YES	NO	If YES, level of pain (01-10)
7b. Front of Upper Leg - L [ynLegFrontUpL]	51 1	0	52-53 [lvLegFrontUpL]
8a. Front of Lower Leg - R [ynLegFrontLowR]	54 1	0	55-56 [lvLegFrontLowR]
8b. Front of Lower Leg - L [ynLegFrontLowL]	57 1	0	58-59 [lvLegFrontLowL]
9a. Top of Foot - R [ynFootTopR]	60 1	0	61-62 [lvFootTopR]
9b. Top of Foot - L [ynFootTopL]	63 1	0	64-65 [lvFootTopL]
10. Scalp (Back of Head) [ynScalp]	66 1	0	67-68 [lvScalp]
11. Posterior Cervical (Back of Neck) [ynPostCerv]	69 1	0	70-71 [lvPostCerv]
12. Shoulders / Upper Back [ynBackUp]	72 1	0	73-74 [lvBackUp]
13. Mid Back [ynBackMid]	75 1	0	76-77 [lvBackMid]
14. Lower Back [ynBackLow]	78 1	0	79-80 [lvBackLow]
15a. Back of Hand - R [ynHandBackR]	81 1	0	82-83 [lvHandBackR]
15b. Back of Hand - L [ynHandBackL]	84 1	0	85-86 [lvHandBackL]
16a. Gluteal (Buttocks) - R [ynGlutR]	87 1	0	88-89 [lvGlutR]
16b. Gluteal (Buttocks) - L [ynGlutL]	90 1	0	91-92 [lvGlutL]
17a. Back of Upper Leg -R [ynLegBackUpR]	93 1	0	94-95 [lvLegBackUpR]
17b. Back of Upper Leg - L [ynLegBackUpL]	96 1	0	97-98 [lvLegBackUpL]
18a. Back of Lower Leg - R [ynLegBackLowR]	99 1	0	100-101 [lvLegBackLowR]
18b. Back of Lower Leg - L [ynLegBackLowL]	102 1	0	103-104 [lvLegBackLowL]
19a. Bottom of Foot - R [ynFootBottomR]	105 1	0	106-107 [lvFootBottomR]
19b. Bottom of Foot - L [ynFootBottomL]	108 1	0	109-110 [lvFootBottomL]

Form Completed By:_____

REDUCING END-of-LIFE SYMPTOMS WITH TOUCH (REST)

Karnofsky Performance Scale | FORM 05

Instructions: *The On-Site Data Collector (OSDC) should complete this form for each patient at approximately weekly intervals. The Data Collection Visits should be scheduled as follows:*
Baseline Data Collection (Visit #1)--Must occur within 3 working days of enrollment (signing of Consent and HIPAA Forms)
1st Weekly Visit (Visit #2)--Must occur approximately 5 working days from the Baseline Data Collection
2nd Weekly Visit (Visit #3)--Must occur approximately 5 working days from the 1st Weekly Visit (Visit #2)
Final Visit (Visit #4)--Must occur approximately 7 working days following the Final Treatment Visit [Note: For more information about the Final Visit, please refer to Section II, Part D (OSDC) or the instructions for Forms SC-3a-3e in Section III, Part A (OSSTM Forms) of the manual.]

Patient ID: 1-5 ____ - ____ **[subject]** **Patient Initials:** 6-8 ____ **Visit No:** 9 ____ (1 = Visit 1 (baseline); 2 = Visit 2; 3 = Visit 3; 4 = Visit 4 (final)) **[visit]** **Form No:** 10-11 **0 5** **[form]**

1. Date: 12-19 MM DD Year

Removed due to PHI, please see var [daysRandKPS] for number of days between randomization and date of form.

2. Patient location: (Write Number in box) 20 ____ (1 = Home; 2 = Nursing Home/Skilled Nursing Facility; 3 = Hospice Facility; 4 = Other, specify:_____) **[ploc]**

Instructions: *Please complete this scale based on observation of the patient OR patient interview using Response Card #4. Please indicate below your best assessment of the patient's functional status.*

DEFINITION	%	CRITERIA
Able to carry on normal activity and to work. No special care is needed.	100	Normal; no complaints; no evidence of disease
	90	Able to carry on normal activity; minor signs or symptoms of disease
	80	Normal activity with effort; some signs or symptoms of disease
Unable to work. Able to live at home, care for most personal needs. A varying amount of assistance is needed.	70	Cares for self. Unable to carry on normal activity or to do active work
	60	Requires occasional assistance, but is able to care for most of his/her needs
	50	Requires considerable assistance and frequent medical care
	40	Disabled; requires special care and assistance
Unable to care for self. Requires equivalent of institutional or hospital care. Disease may be progressing rapidly.	30	Severely disabled; hospitalization is indicated although death not imminent
	20	Very sick; hospitalization necessary, active supportive treatment necessary
	10	Moribund; fatal processes progressing rapidly
	0	Dead

Instructions: *Please enter your best assessment of the patient's functional status in the boxes below. If the assessment rating is less than 3 digits, please place a zero in the first box.*

3. ASSESSMENT RATING: 21-23 ____ **[kps]**

Form Completed by:_____

REDUCING END-of-LIFE SYMPTOMS WITH TOUCH (REST)

Brief Pain Inventory (BPI) | FORM 06

Instructions: *The On-Site Data Collector (OSDC) should complete this form for each patient at approximately weekly intervals. The Data Collection Visits should be scheduled as follows: Baseline Data Collection (Visit #1)--Must occur within 3 working days of enrollment (signing of Consent and HIPAA Forms) 1st Weekly Visit (Visit #2)--Must occur approximately 5 working days from the Baseline Data Collection 2nd Weekly Visit (Visit #3)--Must occur approximately 5 working days from the 1st Weekly Visit (Visit #2) Final Visit (Visit #4)--Must occur approximately 7 working days following the Final Treatment Visit [Note: For more information about the Final Visit, please refer to Section II, Part D (OSDC) or the instructions for Forms SC-3a-3e in Section III, Part A (OSSTM Forms) of the manual.]*

Patient ID: 1-5 ☐☐-☐☐☐ **[subject]** **Patient Initials:** 6-8 ☐☐☐ **Visit No:** 9 ☐ (1 = Visit 1 (baseline), 2 = Visit 2, 3 = Visit 3, 4 = Visit 4 (final)) **[visit]** **Form No:** 10-11 0 6 **[form]**

1. Date: 12-19 ☐☐ MM ☐☐ DD ☐☐☐☐ Year

2. Patient location: (Write Number in box) 20 ☐
   1 = Home
   2 = Nursing Home/Skilled Nursing Facility
   3 = Hospice Facility
   4 = Other, specify:_____ **[ploc]**

Removed due to PHI, please see var [daysRandBPI] for number of days between randomization and date of form.

Instructions: Please record the number indicated by the patient using Response Card #5 in the boxes beside each scale. If the patient's response is less than 2 digits, please place a zero in the first box.

3. **Brief Pain Inventory:**

a. Please rate your pain by indicating on the card the one number that best describes your pain at its **worst** in the last week:

0 (No Pain) 1 2 3 4 5 6 7 8 9 10 (Pain as bad as you can imagine) 21-22 ☐☐ **[bpiWorstWk]**

b. Please rate your pain by indicating on the card the one number that best describes your pain at its **least** in the last week:

0 (No Pain) 1 2 3 4 5 6 7 8 9 10 (Pain as bad as you can imagine) 23-24 ☐☐ **[bpiLeastWk]**

c. Please rate your pain by indicating on the card the one number that best describes your pain on the **average:**

0 (No Pain) 1 2 3 4 5 6 7 8 9 10 (Pain as bad as you can imagine) 25-26 ☐☐ **[bpiAvg]**

d. Please rate your pain by indicating on the card the one number that tells how much pain you have **right now:**

0 (No Pain) 1 2 3 4 5 6 7 8 9 10 (Pain as bad as you can imagine) 27-28 ☐☐ **[bpiNow]**

REDUCING END-of-LIFE SYMPTOMS WITH TOUCH (REST)

Brief Pain Inventory (BPI) | FORM 06

Patient ID: 1-5 [ ][ ]-[ ][ ][ ] [subject] **Patient Initials:** 6-8 [ ][ ][ ] **Visit No:** 9 [ ] (1 = Visit 1 (baseline), 2 = Visit 2, 3 = Visit 3, 4 = Visit 4 (final)) [visit] **Form No:** 10-11 0 6 [form]

3. CONTINUED:

e. Indicate on the card the one number that best describes how, during the past week, pain has interfered with your:

1) **General Activity**

0 Does not Interfere 1 2 3 4 5 6 7 8 9 10 Completely Interferes

29-30 [ ][ ] [bpiIntGenAct]

2) **Mood:**

0 Does not Interfere 1 2 3 4 5 6 7 8 9 10 Completely Interferes

31-32 [ ][ ] [bpiIntMood]

3) **Walking ability:**

0 Does not Interfere 1 2 3 4 5 6 7 8 9 10 Completely Interferes

33-34 [ ][ ] [bpiIntWalk]

4) **Normal work (includes both work outside the home and housework):** ***[This question may not apply to the patient. If this is the case, please write "not applicable" or "NA" next to it.]***

0 Does not Interfere 1 2 3 4 5 6 7 8 9 10 Completely Interferes

35-36 [ ][ ] [bpiIntWork]

5) **Relations with other people:**

0 Does not Interfere 1 2 3 4 5 6 7 8 9 10 Completely Interferes

37-38 [ ][ ] [bpiIntRel]

6) **Sleep:**

0 Does not Interfere 1 2 3 4 5 6 7 8 9 10 Completely Interferes

39-40 [ ][ ] [bpiIntSleep]

7) **Enjoyment of life:**

0 Does not Interfere 1 2 3 4 5 6 7 8 9 10 Completely Interferes

41-42 [ ][ ] [bpiIntEnjoy]

Form Completed by:_____

REDUCING END-of-LIFE SYMPTOMS WITH TOUCH (REST)

Condensed Memorial Symptom Assessment Scale (MSAS) | FORM 07

Instructions: *The On-Site Data Collector (OSDC) should complete this form for each patient at approximately weekly intervals. The Data Collection Visits should be scheduled as follows:*
Baseline Data Collection (Visit #1)--Must occur within 3 working days of enrollment (signing of Consent and HIPAA Forms)
1st Weekly Visit (Visit #2)--Must occur approximately 5 working days from the Baseline Data Collection
2nd Weekly Visit (Visit #3)--Must occur approximately 5 working days from the 1st Weekly Visit (Visit #2)
Final Visit (Visit #4)--Must occur approximately 7 working days following the Final Treatment Visit [Note: For more information about the Final Visit, please refer to Section II, Part D (OSDC) or the instructions for Forms SC-3a-3e in Section III, Part A (OSSTM Forms) of the manual.]

Patient ID: 1-5 ____ - ____ [subject] **Patient Initials:** 6-8 ____ **Visit No:** 9 ____ (1 = Visit 1 (baseline); 2 = Visit 2; 3 = Visit 3; 4 = Visit 4 (final)) [visit] **Form No:** 10-11 0 7 [form]

1. Date: 12-19 MM DD Year

Removed due to PHI, please see var [daysRandMSAS] for number of days between randomization and date of form.

2. Patient location: 20 ____ (Write Number in box)
1 = Home
2 = Nursing Home/Skilled Nursing Facility
3 = Hospice Facility
4 = Other, specify:_____ [ploc]

Instructions: Please ask the patient if each symptom is present using Response Card #6 and indicate below. If present, then please mark one box to indicate how much each symptom bothers/distresses the patient. If not present, then please ONLY mark a response to the yes/no question; do NOT mark a response to the bother/distress question.

3. Condensed Memorial Symptom Assessment Scale (MSAS) [Modified]:

Symptom	Present: Yes	Present: No		If present, how much did symptom bother or distress you in past 7 days? Not at All	A little bit	Some-what	Quite a bit	Very much	
a. Lack of energy	21 1	0	[msasEnergy]	22 1	2	3	4	5	[msasEnergyDstrs]
b. Lack of appetite	23 1	0	[msasApp]	24 1	2	3	4	5	[msasAppDstrs]
c. Pain	25 1	0	[msasPain]	26 1	2	3	4	5	[msasPainDstrs]
d. Dry mouth	27 1	0	[msasDryMth]	28 1	2	3	4	5	[msasDryMthDstrs]
e. Weight loss	29 1	0	[msasWghtLs]	30 1	2	3	4	5	[msasWghtLsDstrs]
f. Feeling drowsy	31 1	0	[msasDrwsy]	32 1	2	3	4	5	[msasDrwsyDstrs]
g. Shortness of breath	33 1	0	[msasSOB]	34 1	2	3	4	5	[msasSOBDstrs]
h. Nausea	35 1	0	[msasNaus]	36 1	2	3	4	5	[msasNausDstrs]
i. Constipation	37 1	0	[msasConst]	38 1	2	3	4	5	[msasConstDstrs]
j. Cough	39 1	0	[msasCough]	40 1	2	3	4	5	[msasCoughDstrs]
k. Swelling of arms or legs	41 1	0	[msasSwell]	42 1	2	3	4	5	[msasSwellDstrs]
l. Difficulty swallowing	43 1	0	[msasSwllw]	44 1	2	3	4	5	[msasSwllwDstrs]

REDUCING END-of-LIFE SYMPTOMS WITH TOUCH (REST)

Condensed Memorial Symptom Assessment Scale (MSAS) | FORM 07

Patient ID: 1-5 [ ][ ]-[ ][ ][ ] [subject]

Patient Initials: 6-8 [ ][ ][ ]

Visit No: 9 [ ] (1 = Visit 1 (baseline), 2 = Visit 2, 3 = Visit 3, 4 = Visit 4 (final)) [visit]

Form No: 10-11 [0][7] [form]

Symptom	Present: Yes	Present: No	If present, how frequently did symptom bother or distress you in past 7 days? Rarely	Occa-sionally	Fre-quently	Almost constantly	
m. Worrying	45 [1]	[0] [msasWorry]	46 [1]	[2]	[3]	[4]	[msasWorryDstrs]
n. Feeling sad	47 [1]	[0] [msasSad]	48 [1]	[2]	[3]	[4]	[msasSadDstrs]
o. Feeling nervous	49 [1]	[0] [msasNerv]	50 [1]	[2]	[3]	[4]	[msasNervDstrs]
p. Feeling irritable	51 [1]	[0] [msasIrrit]	52 [1]	[2]	[3]	[4]	[msasIrritDstrs]
q. Difficulty concentrating	53 [1]	[0] [msasDiffConc]	54 [1]	[2]	[3]	[4]	[msasDiffConcDstrs]

Form Completed by:_____

REDUCING END-of-LIFE SYMPTOMS WITH TOUCH (REST)

McGill Quality of Life Questionnaire (MQOL) | FORM 08

Instructions: *The On-Site Data Collector (OSDC) should complete this form for each patient at approximately weekly intervals. The Data Collection Visits should be scheduled as follows:*
Baseline Data Collection (Visit #1)--Must occur within 3 working days of enrollment (signing of Consent and HIPAA Forms)
1st Weekly Visit (Visit #2)--Must occur approximately 5 working days from the Baseline Data Collection
2nd Weekly Visit (Visit #3)--Must occur approximately 5 working days from the 1st Weekly Visit (Visit #2)
Final Visit (Visit #4)--Must occur approximately 7 working days following the Final Treatment Visit [Note: For more information about the Final Visit, please refer to Section II, Part D (OSDC) or the instructions for Forms SC-3a-3e in Section III, Part A (OSSTM Forms) of the manual.]

Patient ID: 1-5 ☐☐-☐☐☐ [subject] **Patient Initials:** 6-8 ☐☐☐ **Visit No:** 9 ☐ (1 = Visit 1 (baseline), 2 = Visit 2, 3 = Visit 3, 4 = Visit 4 (final)) [visit] **Form No:** 10-11 0 8 [form]

Removed due to PHI, please see var [daysRandMQOL] for number of days between randomization and date of form

1. Date: 12-19 ☐☐ MM ☐☐ DD ☐☐☐☐ Year

2. Patient location: (Write Number in box) 20 ☐
1 = Home
2 = Nursing Home/Skilled Nursing Facility
3 = Hospice Facility
4 = Other, specify:_____ [ploc]

Instructions: Please record the number indicated by the patient using Response Card #7 in the boxes beside each question. If the patient's response is less than 2 digits, please place a zero in the first box.

3. McGill Quality of Life Questionnaire (MQOL) [Modified]

Overall Quality of Life		
a. Considering all parts of my life-emotional, social, spiritual, and financial-*over the past two days* the quality of my life has been:	very bad ... excellent 0 1 2 3 4 5 6 7 8 9 10	[mqolOverall] 21-22 ☐☐

Begin each question with 'Over the past two days'.

Physical Well-Being		
b. I have felt.....	physically terrible ... physically well 0 1 2 3 4 5 6 7 8 9 10	[mqolPhys] 23-24 ☐☐
Existential		
c. My life has been.....	utterly meaningless and without purpose ... very purposeful and meaningful 0 1 2 3 4 5 6 7 8 9 10	[mqolExtPurpose] 25-26 ☐☐
d. When I thought about my whole life, I felt that in achieving life goals I have.....	made no progress whatsoever ... progressed to complete fulfillment 0 1 2 3 4 5 6 7 8 9 10	[mqolExtGoals] 27-28 ☐☐
e. When I thought about my whole life, I felt that my life to this point has been.....	completely worthless ... very worthwhile 0 1 2 3 4 5 6 7 8 9 10	[mqolExtWorth] 29-30 ☐☐
f. I have felt that I have.....	no control over life ... complete control over life 0 1 2 3 4 5 6 7 8 9 10	[mqolExtControl] 31-32 ☐☐
g. I have felt good about myself as a person.....	completely disagree ... completely agree 0 1 2 3 4 5 6 7 8 9 10	[mqolExtSelf] 33-34 ☐☐
h. To me, the past two days were.....	a burden ... a gift 0 1 2 3 4 5 6 7 8 9 10	35-36 ☐☐
Support		[mqolExtGift]
i. The world has been.....	an impersonal, unfeeling place ... caring and responsive to my needs 0 1 2 3 4 5 6 7 8 9 10	[mqolSupWorld] 37-38 ☐☐
j. I have felt supported.....	not at all ... completely 0 1 2 3 4 5 6 7 8 9 10	[mqolSupFelt] 39-40 ☐☐

Form Completed by:_____

REDUCING END-of-LIFE SYMPTOMS WITH TOUCH (REST)

Pharmacologic Interventions | FORM 09

Instructions:

- Please complete this form at each scheduled Data Collection Visit.
- Record ALL medications used to decrease symptoms for this patient in the 24 hours prior to each Data Collection Visit.
- This information should be obtained from medical records, the patient/family/caregivers, and/or nursing staff. (An in-home medication log is available for voluntary use.)
- Place a check mark in the box to the left of each therapy used (with the appropriate route of administration if a narcotic), then indicate the dose and the total number of doses received in the prior 24 hours.

Narcotics & Average Dose:

If you are unable to complete the entire Form 09, then the most important medications to get information about are narcotics (Questions #3 and 4 on pages 2 and 3). Narcotics are listed by name and route of administration. Possible routes of administration include: intramuscular (IM), intrathecal (IT), intravenous (IV), oral, rectal, subcutaneous (SQ), and transdermal. A patient may be receiving a narcotic through one or more of these routes. Please mark the appropriate medication-route combination(s).

Narcotics are being converted to morphine equivalents for analysis purposes. Please calculate the average dose if a patient received a narcotic (or other medication) with:

Example #1: A range of doses (via the same route of administration for narcotics).

A patient received two different dose amounts of Morphine in the past 24 hours.

Patient Received: Morphine 3 mg x 2 doses AND Morphine 4 mg x 1 dose

To Enter Data on Form 09:

Add the total number of doses to use in the average dose calculation below and to put in the "Total # of Doses in the past 24 hours" column, e.g. 2 doses + 1 dose = 3 doses

Calculate the average dose of the medication to put in the "Dose" column

$$\text{Total Amount} = \frac{(3\text{ mg} \times 2) + (4\text{ mg} \times 1)}{\text{No of Doses}} = \frac{6\text{ mg} + 4\text{ mg}}{3\text{ doses}} = \frac{10\text{ mg}}{3\text{ doses}} = 3.3\text{ mg/dose}$$

Example #2: A dose via more than one route of administration, and two or more of the routes are listed together on Form 09 (only for narcotics).

A patient received Morphine both intravenously (IV) and subcutaneously (SQ) in the past 24 hours.

Patient Received: Morphine 10 mg IV x 4 doses AND Morphine 5 mg SQ x 1 dose

To Enter Data on Form 09:

Add the total number of doses to use in the average dose calculation below and to put in the "Total # of Doses in the past 24 hours" column, e.g. 4 doses + 1 dose = 5 doses

Calculate the average dose of the medication to put in the "Dose" column

$$\text{Total Amount} = \frac{(10\text{ mg} \times 4) + (5\text{ mg} \times 1)}{\text{No of Doses}} = \frac{40\text{ mg} + 5\text{ mg}}{5\text{ doses}} = \frac{45\text{ mg}}{5\text{ doses}} = 9\text{ mg/dose}$$

REDUCING END-of-LIFE SYMPTOMS WITH TOUCH (REST)

Pharmacologic Interventions | FORM 09

Instructions: *The On-Site Data Collector (OSDC) should complete this form for each patient at approximately weekly intervals. The Data Collection Visits should be scheduled as follows:*
Baseline Data Collection (Visit #1)--Must occur within 3 working days of enrollment (signing of Consent and HIPAA Forms)
1st Weekly Visit (Visit #2)--Must occur approximately 5 working days from the Baseline Data Collection
2nd Weekly Visit (Visit #3)--Must occur approximately 5 working days from the 1st Weekly Visit (Visit #2)
Final Visit (Visit #4)--Must occur approximately 7 working days following the Final Treatment Visit [Note: For more information about the Final Visit, please refer to Section II, Part D (OSDC) or the instructions for Forms SC-3a-3e in Section III, Part A (OSSTM Forms) of the manual.]

Patient ID: 1-5 ____ - [subject] **Patient Initials:** 6-8 ____ **Visit No:** 9 ____ (1 = Visit 1 (baseline), 2 = Visit 2, 3 = Visit 3, 4 = Visit 4 (final)) [visit] **Form No:** 10-11 0 9 [form]

1. Date: 12-19 MM DD Year

Removed due to PHI please see var [daysRandPharmInt] for number of days between randomization and date of form.

2. Patient location: 20 ____ *(Write Number in box)*
1 = Home
2 = Nursing Home/Skilled Nursing Facility
3 = Hospice Facility
4 = Other, specify:_____
[ploc]

PHARMACOLOGIC INTERVENTIONS for SYMPTOMS

(Please see instructions on Page 1)

3. Narcotics:

Attach [-Dose] at end of base variable name

Attach [DoseN] at end of base variable name

Medication Name	Dose	Total # of Doses in past 24 hours
1a. 21 ____ Codeine - Oral [narcCodePO]	1b. 22-24 ____ mg	1c. 25-27 ____
2a. 28 ____ Fentanyl, long-acting (Duragesic patch) - Transdermal [narcFentLATD]	2b. 29-31 ____ mcg	2c. 32-34 ____
3a. 35 ____ Fentanyl, short-acting - IM, IT, IV [narcFentSAIVIM]	3b. 36-38 ____ mcg	3c. 39-41 ____
4a. 42 ____ Fentanyl, short-acting (Actiq) - Oral [narcFentSAPO]	4b. 43-45 ____ mcg	4c. 46-48 ____
5a. 49 ____ Hydromorphone (Dilaudid) - Oral, Rectal [narcHydrPOPR]	5b. 50-52 ____ mg	5c. 53-55 ____
6a. 56 ____ Hydromorphone (Dilaudid) - IM, IT, IV, SQ [narcHydrIVIMSQ]	6b. 57-59 ____ mg	6c. 60-62 ____
7a. 63 ____ Levorphanol (Levo-Dromoran) - Oral [narcLevoPO]	7b. 64-66 ____ mg	7c. 67-69 ____
8a. 70 ____ Meperidine (Demerol) - Oral [narcMepePO]	8b. 71-73 ____ mg	8c. 74-76 ____
9a. 77 ____ Meperidine (Demerol) - IM, IT, IV, SQ [narcMepeIVIMSQ]	9b. 78-80 ____ mg	9c. 81-83 ____
10a. 84 ____ Methadone - Oral [narcMethPO]	10b. 85-87 ____ mg	10c. 88-90 ____
11a. 91 ____ Morphine, long-acting (e.g. MS Contin, Oramorph, Kadian, Avinza) - Oral, Rectal [narcMorpLAPOPR]	11b. 92-94 ____ mg	11c. 95-97 ____
12a. 98 ____ Morphine, short-acting (e.g. Roxanol, MSIR) - Oral, Rectal [narcMorpSAPOPR]	12b. 99-101 ____ mg	12c. 102-104 ____
13a. 105 ____ Morphine, short-acting - IM, IT, IV, SQ [narcMorpSAIVIMSQ]	13b. 106-108 ____ mg	13c. 109-111 ____

IM = intramuscular
IT = intrathecal
IV = intravenous
SQ = subcutaneous

REDUCING END-of-LIFE SYMPTOMS WITH TOUCH (REST)

Pharmacologic Interventions | FORM 09

Patient ID: 1-5 [ ][ ]-[ ][ ][ ] [subject]

Patient Initials: 6-8 [ ][ ][ ]

Visit No: 9 [ ] (1 = Visit 1 (baseline), 2 = Visit 2, 3 = Visit 3, 4 = Visit 4 (final)) [visit]

Form No: 10-11 0 9 [form]

3. Narcotics - CONTINUED:

Attach [-Dose] at end of base variable name

Attach [DoseN] at end of base variable name

Medication Name	Dose	Total # of Doses in past 24 hours
14a. 112 [ ] Oxycodone, long-acting (Oxycontin) - Oral [narcOxycLAPO]	14b. 113-115 [ ][ ][ ] mg	14c. 116-118 [ ][ ][ ]
15a. 119 [ ] Oxycodone, short-acting (Roxicodone) - Oral [narcOxycSAPO]	15b. 120-122 [ ][ ][ ] mg	15c. 123-125 [ ][ ][ ]
16a. 126 [ ] Propoxyphene (e.g. Darvon, Darvon-N) - Oral [narcPropPO]	16b. 127-129 [ ][ ][ ] mg	16c. 130-132 [ ][ ][ ]
17a. 133 [ ] Other:_____ [narcOthrPOPR] - Oral, Rectal	17b. [ ][ ][ ] mg	17c. [ ][ ][ ]
18a. 134 [ ] Other:_____ [narcOthrIVIMSQ] - IM, IT, IV, SQ	18b. [ ][ ][ ] mg	18c. [ ][ ][ ]

4. Narcotic Combinations:

Attach [-Dose] at end of base variable name

Attach [DoseN] at end of base variable name

Medication Name	Dose	Total # of Doses in past 24 hours
1. 135 [ ] Acetaminophen/Codeine [narcombAcetCode]	136 [ ] 1 = Tylenol #2, 2 = Tylenol #3, 3 = Tylenol #4	137-139 [ ][ ][ ]
2. 140 [ ] Acetaminophen/Hydrocodone (e.g. Vicoden, Lortab, Lorcet, Hyco-pap, Maxidone, Zydone) [narcombAcetHydr]	141 [ ] 1 = 2.5 mg hydrocodone, 2 = 5 mg hydrocodone, 3 = 7.5 mg hydrocodone, 4 = 10 mg hydrocodone	142-144 [ ][ ][ ]
3. 145 [ ] Acetaminophen/Oxycodone (e.g. Percocet, Endocet, Roxicet, Tylox) [narcombAcetOxyc]	146 [ ] 1 = 2.5 mg oxycodone, 2 = 5 mg oxycodone, 3 = 7.5 mg oxycodone, 4 = 10 mg oxycodone	147-149 [ ][ ][ ]
4. 150 [ ] Acetaminophen/Propoxyphene [narcombAcetProp]	151 [ ] 1 = Darvocet N-100, 2 = Darvocet N-50	152-154 [ ][ ][ ]
5. 155 [ ] Aspirin (ASA)/Hydrocodone (Percodan) [narcombASAPerc]	156 [ ] 1 = 2.25 mg oxycodone, 2 = 4.5 mg oxycodone	157-159 [ ][ ][ ]
6. 160 [ ] Fioricet [narcombFiot]	N/A	161-163 [ ][ ][ ]
7. 164 [ ] Fiorinal [narcombFiol]	N/A	165-167 [ ][ ][ ]
8. 168 [ ] Ibuprofen/Hydrocodone (Vicoprofen) [narcombVico]	N/A	169-171 [ ][ ][ ]
9. 172 [ ] Other:_____ [narcombOthr]	[ ][ ][ ] _____ (mg, mcg)	[ ][ ][ ]

IM = intramuscular
IT = intrathecal
IV = intravenous
SQ = subcutaneous

REDUCING END-of-LIFE SYMPTOMS WITH TOUCH (REST)

Pharmacologic Interventions | FORM 09

Patient ID: 1-5 [ ][ ] - [subject] [ ][ ][ ]

Patient Initials: 6-8 [ ][ ][ ]

Visit No: 9 [ ] (1 = Visit 1 (baseline), 2 = Visit 2, 3 = Visit 3, 4 = Visit 4 (final)) [visit]

Form No: 10-11 0 9 [form]

5. Non-Steroidal Anti-Inflammatory Medications (NSAIDS):

Attach [-Dose] at end of base variable name

Attach [DoseN] at end of base variable name

Medication Name	Dose	Total # of Doses in past 24 hours
1. 173 [ ] Celecoxib (Celebrex) [nsaidCele]	174 [ ] 1 = 100 mg; 2 = 200 mg; 3 = 400 mg	175-177 [ ][ ][ ]
2. 178 [ ] Diclofenac (e.g. Cataflam, Voltaren) [nsaidDicl]	179 [ ] 1 = 25 mg; 2 = 50 mg; 3 = 75 mg; 4 = 100 mg	180-182 [ ][ ][ ]
3. 183 [ ] Diclofenac/Misoprostol (Arthrotec) [nsaidDiclMiso]	184 [ ] 1 = 50 mg diclofenac; 2 = 75 mg diclofenac	185-187 [ ][ ][ ]
4. 188 [ ] Diflunisal (Dolobid) [nsaidDifl]	189 [ ] 1 = 250 mg; 2 = 500 mg	190-192 [ ][ ][ ]
5. 193 [ ] Etodolac (Lodine) [nsaidEtod]	194 [ ] 1 = 200 mg; 2 = 300 mg; 3 = 400 mg; 4 = 500 mg; 5 = 600 mg	195-197 [ ][ ][ ]
6. 198 [ ] Flurbiprofen (Ansaid) [nsaidFlur]	199 [ ] 1 = 50 mg; 2 = 100 mg	200-202 [ ][ ][ ]
7. 203 [ ] Ibuprofen (e.g. Motrin, Advil) [nsaidIbup]	204 [ ] 1 = 100 mg; 2 = 200 mg; 3 = 300 mg; 4 = 400 mg; 5 = 600 mg; 6 = 800 mg	205-207 [ ][ ][ ]
8. 208 [ ] Indomethacin (Indocin) [nsaidIndo]	209 [ ] 1 = 25 mg; 2 = 50 mg; 3 = 75 mg	210-212 [ ][ ][ ]
9. 213 [ ] Ketoprofen (e.g. Orudis, Oruvail) [nsaidKetop]	214 [ ] 1 = 50 mg; 2 = 75 mg; 3 = 100 mg; 4 = 150 mg; 5 = 200 mg	215-217 [ ][ ][ ]
10. 218 [ ] Ketorolac (Toradol) [nsaidKetor]	219 [ ] 1 = 10 mg; 2 = ____ mg	220-222 [ ][ ][ ]
11. 223 [ ] Meloxicam (Mobic) [nsaidMelo]	224 [ ] 1 = 7.5 mg; 2 = 15 mg	225-227 [ ][ ][ ]
12. 228 [ ] Nabumetone (Relafen) [nsaidNabu]	229 [ ] 1 = 500 mg; 2 = 750 mg	230-232 [ ][ ][ ]
13. 233 [ ] Naproxen (e.g. Anaprox, Naprelan, Naprosyn) [nsaidNapr]	234 [ ] 1 = 250 mg; 2 = 375 mg; 3 = 500 mg; 4 = 550 mg	235-237 [ ][ ][ ]

REDUCING END-of-LIFE SYMPTOMS WITH TOUCH (REST)

Pharmacologic Interventions | FORM 09

Patient ID: 1-5 [ ][ ] - [subject] [ ][ ][ ]

Patient Initials: 6-8 [ ][ ][ ]

Visit No: 9 [ ] (1 = Visit 1 (baseline), 2 = Visit 2, 3 = Visit 3, 4 = Visit 4 (final)) [visit]

Form No: 10-11 0 9 [form]

5. Non-Steroidal Anti-Inflammatory Medications (NSAIDS) - CONTINUED:

Attach [DoseN] at end of base variable name

Medication Name	Dose (Attach [-Dose] at end of base variable name)	Total # of Doses in past 24 hours
14. 238 [ ] Oxaprozin (Daypro) [nsaidOxap]	239 [ ] 600 mg	240-242 [ ][ ][ ]
15. 243 [ ] Piroxicam (Feldene) [nsaidPiro]	244 [ ] 1 = 10 mg; 2 = 20 mg	245-247 [ ][ ][ ]
16. 248 [ ] Rofecoxib (Vioxx) [nsaidRofe]	249 [ ] 1 = 12.5 mg; 2 = 25 mg; 3 = 50 mg	250-252 [ ][ ][ ]
17. 253 [ ] Sulindac (Clinoril) [nsaidSuli]	254 [ ] 1 = 150 mg; 2 = 200 mg	255-257 [ ][ ][ ]
18. 258 [ ] Tolmetin (Tolectin) [nsaidTolm]	259 [ ] 1 = 200 mg; 2 = 400 mg; 3 = 600 mg	260-262 [ ][ ][ ]
19. 263 [ ] Valdecoxib (Bextra) [nsaidVald]	264 [ ] 1 = 10 mg; 2 = 20 mg	265-267 [ ][ ][ ]
20. 268 [ ] Other_____ [nsaidOthr] _____	[ ][ ][ ] _____ (mg, mcg)	[ ][ ][ ]

6. Muscle Relaxants:

Attach [-Dose] at end of base variable name

Attach [DoseN] at end of base variable name

1. 269 [ ] Baclofen [mrlxBacl]	270 [ ] 1 = 10 mg; 2 = 20 mg	271-273 [ ][ ][ ]
2. 274 [ ] Carisoprodol (Soma) [mrlxCari]	275 [ ] 350 mg	276-278 [ ][ ][ ]
3. 279 [ ] Chlorzoxazone (Parafon Forte) [mrlxChlo]	280 [ ] 500 mg	281-283 [ ][ ][ ]
4. 284 [ ] Cyclobenzaprine (Flexeril) [mrlxCycl]	285 [ ] 10 mg	286-288 [ ][ ][ ]
5. 289 [ ] Metaxalone (Skelaxin) [mrlxMeta]	290 [ ] 1 = 400 mg; 2 = 800 mg	291-293 [ ][ ][ ]
6. 294 [ ] Methocarbamol (Robaxin) [mrlxMeth]	295 [ ] 1 = 400 mg; 2 = 750 mg	296-298 [ ][ ][ ]
7. 299 [ ] Orphenadrine (Norflex) [mrlxOrph]	300 [ ] 1 = 50 mg; 2 = 100 mg	301-303 [ ][ ][ ]
8. 304 [ ] Tizanidine (Zanaflex) [mrlxTiza]	305 [ ] 1 = 2 mg; 2 = 4 mg	306-308 [ ][ ][ ]
9. 309 [ ] Other:_____ [mrlxOthr] _____	[ ][ ][ ] _____ (mg, mcg)	[ ][ ][ ]

REDUCING END-of-LIFE SYMPTOMS WITH TOUCH (REST)

Pharmacologic Interventions | FORM 09

Patient ID: 1-5 [ ][ ] - [subject] [ ][ ][ ]

Patient Initials: 6-8 [ ][ ][ ]

Visit No: 9 [ ] (1 = Visit 1 (baseline), 2 = Visit 2, 3 = Visit 3, 4 = Visit 4 (final)) [visit]

Form No: 10-11 0 9 [form]

7. Other Analgesics:

Attach [-Dose] at end of base variable name

Attach [DoseN] at end of base variable name

Medication Name	Dose	Total # of Doses in past 24 hours
1. 310 [ ] Acetaminophen (Tylenol) [analgAcet]	311 [ ] 1 = 325 mg, 2 = 500 mg	312-314 [ ][ ][ ]
2. 315 [ ] Tramadol (Ultram) [analgTram]	316 [ ] 50 mg	317-319 [ ][ ][ ]
3. 320 [ ] Other: [analgOthr1]	[ ][ ][ ] _____ (mg, mcg)	[ ][ ][ ]
4. 321 [ ] Other: [analgOthr2]	[ ][ ][ ] _____ (mg, mcg)	[ ][ ][ ]

8. Adjuvant Pain Medications:

Medication Name	Dose	Total # of Doses in past 24 hours
[adjuAmit] 1. 322 [ ] Amitriptyline (e.g. Elavil, Endep)	323 [ ] 1 = 10 mg, 2 = 25 mg, 3 = 50 mg, 4 = 75 mg, 5 = 100 mg, 6 = 150 mg	324-326 [ ][ ][ ]
[adjuCarb] 2. 327 [ ] Carbamazepine (e.g. Carbatrol, Tegretol)	328 [ ] 1 = 100 mg, 2 = 200 mg, 3 = 300 mg	329-331 [ ][ ][ ]
[adjuDesi] 3. 332 [ ] Desipramine (Norpramin)	333 [ ] 1 = 10 mg, 2 = 25 mg, 3 = 50 mg, 4 = 75 mg, 5 = 100 mg, 6 = 150 mg	334-336 [ ][ ][ ]
[adjuDext] 4. 337 [ ] Dextroamphetamine (Dexedrine)	338 [ ] 1 = 5 mg, 2 = 10 mg, 3 = 15 mg	339-341 [ ][ ][ ]
[adjuDoxe] 5. 342 [ ] Doxepin (Sinequan)	343 [ ] 1 = 10 mg, 2 = 25 mg, 3 = 50 mg, 4 = 75 mg, 5 = 100 mg, 6 = 150 mg	344-346 [ ][ ][ ]
[adjuGaba] 6. 347 [ ] Gabapentin (Neurontin)	348 [ ] 1 = 100 mg, 2 = 300 mg, 3 = 400 mg, 4 = 600 mg, 5 = 800 mg	349-351 [ ][ ][ ]

REDUCING END-of-LIFE SYMPTOMS WITH TOUCH (REST)

Pharmacologic Interventions | FORM 09

Patient ID: 1-5 [ ][ ] - [subject] [ ][ ][ ]

Patient Initials: 6-8 [ ][ ][ ]

Visit No: 9 [ ] 1 = Visit 1 (baseline) 2 = Visit 2 3 = Visit 3 4 = Visit 4 (final) [visit]

Form No: 10-11 0 9 [form]

8. Adjuvant Pain Medications - CONTINUED:

Attach [-Dose] at end of base variable name

Attach [DoseN] at end of base variable name

Medication Name	Dose	Total # of Doses in past 24 hours
7. 352 [ ] Imipramine (Tofranil) [adjuImip]	353 [ ] 1 = 10 mg 2 = 25 mg 3 = 50 mg 4 = 75 mg 5 = 100 mg 6 = 150 mg	354-356 [ ][ ][ ]
8. 357 [ ] Methylphenidate (e.g. Methylin, Metadate, Ritalin) [adjuMeth]	358 [ ] 1 = 5 mg 2 = 10 mg 3 = 20 mg	359-361 [ ][ ][ ]
9. 362 [ ] Nortriptyline (e.g. Pamelor, Aventyl) [adjuNort]	363 [ ] 1 = 10 mg 2 = 25 mg 3 = 50 mg 4 = 75 mg	364-366 [ ][ ][ ]
10. 367 [ ] Phenytoin (Dilantin) [adjuPhen]	368 [ ] 1 = 30 mg 2 = 100 mg	369-371 [ ][ ][ ]
11. 372 [ ] Tiagabine (Gabitril) [adjuTiag]	373 [ ] 1 = 2 mg 2 = 4 mg 3 = 12 mg 4 = 16 mg 5 = 20 mg	374-376 [ ][ ][ ]
12. 377 [ ] Valproate (e.g. Depakene, Depakote) [adjuValp]	378 [ ] 1 = 125 mg 2 = 250 mg 3 = 250 mg 4 = 500 mg	379-381 [ ][ ][ ]
13. 382 [ ] Other:_____ [adjuOthr]	[ ][ ][ ] _____ (mg, mcg)	[ ][ ][ ]

9. Anti-Anxiety Medications/Medications for Sleep:

1. 383 [ ] Alprazolam (Xanax) [anxiAlpr]	384 [ ] 1 = 0.25 mg 2 = 0.5 mg 3 = 1 mg 4 = 2 mg	385-387 [ ][ ][ ]
2. 388 [ ] Chlordiazepoxide (Librium) [anxiChlo]	389 [ ] 1 = 5 mg 2 = 10 mg 3 = 25 mg	390-392 [ ][ ][ ]
3. 393 [ ] Clonazepam (Klonapin) [anxiClon]	394 [ ] 1 = 0.5 mg 2 = 1 mg 3 = 2 mg	395-397 [ ][ ][ ]
4. 398 [ ] Clorazepate (Tranxene) [anxiClor]	399 [ ] 1 = 3.75 mg 2 = 7.5 mg 3 = 15 mg	400-402 [ ][ ][ ]
5. 403 [ ] Diazepam (e.g. Dizac, Valium) [anxiDiaz]	404 [ ] 1 = 2.7 mg 2 = 5 mg 3 = 10 mg	405-407 [ ][ ][ ]
6. 408 [ ] Lorazepam (Ativan) [anxiLora]	409 [ ] 1 = 0.5 mg 2 = 1 mg 3 = 2 mg	410-412 [ ][ ][ ]
7. 413 [ ] Oxazepam (Serax) [anxiOxaz]	414 [ ] 1 = 10 mg 2 = 15 mg 3 = 30 mg	415-417 [ ][ ][ ]

REDUCING END-of-LIFE SYMPTOMS WITH TOUCH (REST)

Pharmacologic Interventions | FORM 09

Patient ID: 1-5 [ ][ ] - [subject] Patient Initials: 6-8 [ ][ ][ ] Visit No: 9 [ ] 1 = Visit 1 (baseline) 2 = Visit 2 3 = Visit 3 4 = Visit 4 (final) [visit] Form No: 10-11 0 9 [form]

9. Anti-Anxiety Medications/Medications for Sleep - CONTINUED:

Attach [DoseN] at end of base variable name

Medication Name	Dose Attach [-Dose] at end of base variable name	Total # of Doses in past 24 hours
8. 418 [ ] Temazepam (Restoril) [anxiTema]	419 [ ] 1 = 7.5 mg 2 = 15 mg 3 = 30 mg	420-422 [ ][ ][ ]
9. 423 [ ] Triazolam (Halcion) [anxiTria]	424 [ ] 1 = 0.125 mg 2 = 0.25 mg	425-427 [ ][ ][ ]
10. 428 [ ] Other:_____ [anxiOthr1] _____	[ ][ ][ ] _____(mg, mcg)	[ ][ ][ ]
11. 429 [ ] Other:_____ [anxiOthr2] _____	[ ][ ][ ] _____(mg, mcg)	[ ][ ][ ]

10. Other Medications for Symptom Relief: [If more room is needed for additional medications, please write them under Question #11 and indicate that with an arrow, initials and date.]

Medication Name	Dose (including units, e.g. mg, mcg)	Total # of Doses in past 24 hours
1. 430 [ ] [sympOthrMed1] _____	[ ][ ][ ] _____(mg, mcg)	[ ][ ][ ]
2. 431 [ ] [sympOthrMed2] _____	[ ][ ][ ] _____(mg, mcg)	[ ][ ][ ]
3. 432 [ ] [sympOthrMed3] _____	[ ][ ][ ] _____(mg, mcg)	[ ][ ][ ]
4. 433 [ ] [sympOthrMed4] _____	[ ][ ][ ] _____(mg, mcg)	[ ][ ][ ]

11. Other Interventions to Decrease Symptoms:

1. 434 [ ] Chemotherapy [sympOthrIntChemo]	[ ][ ][ ] _____(mg, mcg)	[ ][ ][ ]
2. 435 [ ] Radiation therapy [sympOthrIntRadia]	[ ][ ][ ] _____(mg, mcg)	[ ][ ][ ]
3. 436 [ ] Other:_____ [sympOthrInt	[ ][ ][ ] _____(mg, mcg)	[ ][ ][ ]
4. 437 [ ] Zolpidem (Ambien) [sympOthrZolp	[ ][ ][ ] _____(mg)	[ ][ ][ ]

Form Completed by:_____

REDUCING END-of-LIFE SYMPTOMS WITH TOUCH (REST)

Non-Pharmacologic Interventions | FORM 10

Instructions: *The On-Site Data Collector (OSDC) should complete this form for each patient at approximately weekly intervals. The Data Collection Visits should be scheduled as follows: Baseline Data Collection (Visit #1)--Must occur within 3 working days of enrollment (signing of Consent and HIPAA Forms) 1st Weekly Visit (Visit #2)--Must occur approximately 5 working days from the Baseline Data Collection 2nd Weekly Visit (Visit #3)--Must occur approximately 5 working days from the 1st Weekly Visit (Visit #2) Final Visit (Visit #4)--Must occur approximately 7 working days following the Final Treatment Visit [Note: For more information about the Final Visit, please refer to Section II, Part D (OSDC) or the instructions for Forms SC-3a-3e in Section III, Part A (OSSTM Forms) of the manual.]*

Patient ID: 1-5 [ ][ ] - [subject] **Patient Initials:** 6-8 [ ][ ][ ] **Visit No:** 9 [ ] (1 = Visit 1 (baseline), 2 = Visit 2, 3 = Visit 3, 4 = Visit 4 (final)) [visit] **Form No:** 10-11 1 0 [form]

1. Date: 12-19 [ ][ ] MM [ ][ ] DD [ ][ ][ ][ ] Year

Removed due to PHI please see var [daysRandNonPharmInt] for number of days between randomization and date of form.

2. Patient location: (Write Number in box) 20 [ ] [ploc]
   1 = Home
   2 = Nursing Home/Skilled Nursing Facility
   3 = Hospice Facility
   4 = Other, specify:_____

3. **Non-Pharmacologic Interventions for Symptoms:** *In the table below, please record OTHER strategies used to decrease the patient's symptoms over the past week. Please obtain this information through patient/caregiver interview, medical records, in-home sign-in sheets, and/or inter-disciplinary team (IDT) meetings. If a patient receives a non-study-related massage, please record that as "08 = Massage Therapy."*

Strategy	Amount of time of each session *(in minutes)*	By Whom
21-22 **a1.** [strat1] *(Select the appropriate answer from the list below and write the numbers in the boxes.)*	23-25 **a2.** [strat1Time] min. *(Write the amount of minutes in the boxes. If less than 3 digits, please place zeros in the appropriate boxes.)*	26 **a3.** [ ] *(Select the appropriate answer from the list below and write one number in the box.)* [strat1Whom]

01 = Acupuncture or Acupressure
02 = Aromatherapy
03 = Art Therapy
04 = Biofeedback, Hypnosis, Relaxation, or Guided Imagery
05 = Chiropractice and/or Cranial-Sacral Therapy
06 = Herbs, Supplements, or Homeopathic remedies
07 = Magnetic Therapies
08 = Massage Therapy
09 = Music or Sound Therapy
10 = Occupational Therapy
11 = Pet Therapy
12 = Physical Therapy or Exercise *(e.g., Yoga, Tai Chi Chuan)*
13 = Psychotherapy or Counseling
14 = Relaxation Therapy
15 = Spiritual Counseling
16 = Therapeutic or Healing Touch, Reiki, or Reflexology

1 = Community Therapist
2 = Faith Community
3 = Family/Friend
4 = Hospice Staff
5 = Volunteer
6 = Other (specify):_____

REDUCING END-of-LIFE SYMPTOMS WITH TOUCH (REST)

Non-Pharmacologic Interventions | FORM 10

Patient ID: 1-5 [ ][ ] - [subject] **Patient Initials:** 6-8 [ ][ ][ ] **Visit No:** 9 [ ] (1 = Visit 1 (baseline), 2 = Visit 2, 3 = Visit 3, 4 = Visit 4 (final)) [visit] **Form No:** 10-11 1 0 [form]

3. Non-Pharmacologic Interventions for Symptoms - CONTINUED:

Strategy	Amount of time of each session *(in minutes)*	By Whom
27-28 **b1.** [strat2] *(Select the appropriate answer from the list below and write the numbers in the boxes.)* 01 = Acupuncture or Acupressure 02 = Aromatherapy 03 = Art Therapy 04 = Biofeedback, Hypnosis, Relaxation, or Guided Imagery 05 = Chiropractice and/or Cranial-Sacral Therapy 06 = Herbs, Supplements, or Homeopathic remedies 07 = Magnetic Therapies 08 = Massage Therapy 09 = Music or Sound Therapy 10 = Occupational Therapy 11 = Pet Therapy 12 = Physical Therapy or Exercise *(e.g., Yoga, Tai Chi Chuan)* 13 = Psychotherapy or Counseling 14 = Relaxation Therapy 15 = Spiritual Counseling 16 = Therapeutic or Healing Touch, Reiki, or Reflexology	29-31 **b2.** [strat2Time] min. *(Write the amount of minutes in the boxes. If less than 3 digits, please place zeros in the appropriate boxes.)*	32 **b3.** [ ] *(Select the appropriate answer from the list below and write <u>one</u> number in the box.)* [strat2Whom] 1 = Community Therapist 2 = Faith Community 3 = Family/Friend 4 = Hospice Staff 5 = Volunteer 6 = Other (specify):_____
33-34 **c1.** [strat3] *(Select the appropriate answer from the list below and write the numbers in the boxes.)* 01 = Acupuncture or Acupressure 02 = Aromatherapy 03 = Art Therapy 04 = Biofeedback, Hypnosis, Relaxation, or Guided Imagery 05 = Chiropractice and/or Cranial-Sacral Therapy 06 = Herbs, Supplements, or Homeopathic remedies 07 = Magnetic Therapies 08 = Massage Therapy 09 = Music or Sound Therapy 10 = Occupational Therapy 11 = Pet Therapy 12 = Physical Therapy or Exercise *(e.g., Yoga, Tai Chi Chuan)* 13 = Psychotherapy or Counseling 14 = Relaxation Therapy 15 = Spiritual Counseling 16 = Therapeutic or Healing Touch, Reiki, or Reflexology	35-37 **c2.** [strat3Time] min. *(Write the amount of minutes in the boxes. If less than 3 digits, please place zeros in the appropriate boxes.)*	38 **c3.** [ ] *(Select the appropriate answer from the list below and write <u>one</u> number in the box.)* [strat3Whom] 1 = Community Therapist 2 = Faith Community 3 = Family/Friend 4 = Hospice Staff 5 = Volunteer 6 = Other (specify):_____

REDUCING END-of-LIFE SYMPTOMS WITH TOUCH (REST)

Non-Pharmacologic Interventions | FORM 10

Patient ID: 1-5 [ ][ ] - [subject] **Patient Initials:** 6-8 [ ][ ][ ] **Visit No:** 9 [ ] (1 = Visit 1 (baseline), 2 = Visit 2, 3 = Visit 3, 4 = Visit 4 (final)) [visit] **Form No:** 10-11 1 0 [form]

3. Non-Pharmacologic Interventions for Symptoms - CONTINUED:

Strategy	Amount of time of each session *(in minutes)*	By Whom
39-40 **d1.** [strat4] *(Select the appropriate answer from the list below and write the numbers in the boxes.)* 01 = Acupuncture or Acupressure 02 = Aromatherapy 03 = Art Therapy 04 = Biofeedback, Hypnosis, Relaxation, or Guided Imagery 05 = Chiropractice and/or Cranial-Sacral Therapy 06 = Herbs, Supplements, or Homeopathic remedies 07 = Magnetic Therapies 08 = Massage Therapy 09 = Music or Sound Therapy 10 = Occupational Therapy 11 = Pet Therapy 12 = Physical Therapy or Exercise *(e.g., Yoga, Tai Chi Chuan)* 13 = Psychotherapy or Counseling 14 = Relaxation Therapy 15 = Spiritual Counseling 16 = Therapeutic or Healing Touch, Reiki, or Reflexology	41-43 **d2.** [strat4Time] min. *(Write the amount of minutes in the boxes. If less than 3 digits, please place zeros in the appropriate boxes.)*	44 **d3.** [ ] *(Select the appropriate answer from the list below and write one number in the box.)* [strat4Whom] 1 = Community Therapist 2 = Faith Community 3 = Family/Friend 4 = Hospice Staff 5 = Volunteer 6 = Other (specify):_____
45-46 **e1.** [strat5] *(Select the appropriate answer from the list below and write the numbers in the boxes.)* 01 = Acupuncture or Acupressure 02 = Aromatherapy 03 = Art Therapy 04 = Biofeedback, Hypnosis, Relaxation, or Guided Imagery 05 = Chiropractice and/or Cranial-Sacral Therapy 06 = Herbs, Supplements, or Homeopathic remedies 07 = Magnetic Therapies 08 = Massage Therapy 09 = Music or Sound Therapy 10 = Occupational Therapy 11 = Pet Therapy 12 = Physical Therapy or Exercise *(e.g., Yoga, Tai Chi Chuan)* 13 = Psychotherapy or Counseling 14 = Relaxation Therapy 15 = Spiritual Counseling 16 = Therapeutic or Healing Touch, Reiki, or Reflexology	47-49 **e2.** [strat5Time] min. *(Write the amount of minutes in the boxes. If less than 3 digits, please place zeros in the appropriate boxes.)*	50 **e3.** [ ] *(Select the appropriate answer from the list below and write one number in the box.)* [strat5Whom] 1 = Community Therapist 2 = Faith Community 3 = Family/Friend 4 = Hospice Staff 5 = Volunteer 6 = Other (specify):_____

REDUCING END-of-LIFE SYMPTOMS WITH TOUCH (REST)

Non-Pharmacologic Interventions | FORM 10

Patient ID: 1-5 [ ][ ] - [subject] **Patient Initials:** 6-8 [ ][ ][ ] **Visit No:** 9 [ ] (1 = Visit 1 (baseline), 2 = Visit 2, 3 = Visit 3, 4 = Visit 4 (final)) [visit] **Form No:** 10-11 1 0 [form]

3. Non-Pharmacologic Interventions for Symptoms - CONTINUED:

Strategy	Amount of time of each session *(in minutes)*	By Whom
f1. 51-52 [strat6] *(Select the appropriate answer from the list below and write the numbers in the boxes.)* 01 = Acupuncture or Acupressure 02 = Aromatherapy 03 = Art Therapy 04 = Biofeedback, Hypnosis, Relaxation, or Guided Imagery 05 = Chiropractice and/or Cranial-Sacral Therapy 06 = Herbs, Supplements, or Homeopathic remedies 07 = Magnetic Therapies 08 = Massage Therapy 09 = Music or Sound Therapy 10 = Occupational Therapy 11 = Pet Therapy 12 = Physical Therapy or Exercise *(e.g., Yoga, Tai Chi Chuan)* 13 = Psychotherapy or Counseling 14 = Relaxation Therapy 15 = Spiritual Counseling 16 = Therapeutic or Healing Touch, Reiki, or Reflexology	**f2.** 53-55 [strat6Time] min. *(Write the amount of minutes in the boxes. If less than 3 digits, please place zeros in the appropriate boxes.)*	**f3.** 56 [ ] *(Select the appropriate answer from the list below and write <u>one</u> number in the box.)* [strat6Whom] 1 = Community Therapist 2 = Faith Community 3 = Family/Friend 4 = Hospice Staff 5 = Volunteer 6 = Other (specify):_____
g1. 57-58 [strat7] *(Select the appropriate answer from the list below and write the numbers in the boxes.)* 01 = Acupuncture or Acupressure 02 = Aromatherapy 03 = Art Therapy 04 = Biofeedback, Hypnosis, Relaxation, or Guided Imagery 05 = Chiropractice and/or Cranial-Sacral Therapy 06 = Herbs, Supplements, or Homeopathic remedies 07 = Magnetic Therapies 08 = Massage Therapy 09 = Music or Sound Therapy 10 = Occupational Therapy 11 = Pet Therapy 12 = Physical Therapy or Exercise *(e.g., Yoga, Tai Chi Chuan)* 13 = Psychotherapy or Counseling 14 = Relaxation Therapy 15 = Spiritual Counseling 16 = Therapeutic or Healing Touch, Reiki, or Reflexology	**g2.** 59-61 [strat7Time] min. *(Write the amount of minutes in the boxes. If less than3 digits, please place zeros in the appropriate boxes.)*	**g3.** 62 [ ] *(Select the appropriate answer from the list below and write <u>one</u> number in the box.)* [strat7Whom] 1 = Community Therapist 2 = Faith Community 3 = Family/Friend 4 = Hospice Staff 5 = Volunteer 6 = Other (specify):_____

REDUCING END-of-LIFE SYMPTOMS WITH TOUCH (REST)

Non-Pharmacologic Interventions | FORM 10

Patient ID: 1-5 [ ][ ] - [subject] **Patient Initials:** 6-8 [ ][ ][ ] **Visit No:** 9 [ ] (1 = Visit 1 (baseline), 2 = Visit 2, 3 = Visit 3, 4 = Visit 4 (final)) [visit] **Form No:** 10-11 [1][0] [form]

4. **Documentation of "Usual Care":** *In the table below, please record the type and length of contact for ALL visits with the patient over the past week. Please mark one type of visit per row. Please do NOT record study-related data collection or touch therapy visits.*

Discipline	Length of time *(minutes)*
a1. 63 [ ] *(Select the appropriate answer from the list below and write one number in the box.)* 1 = Chaplain 2 = Home Health Aid/Certified Nurse Assistant 3 = Nurse (RN or LPN) 4 = Physician 5 = Social Worker 6 = Volunteer 7 = Other: _____ 8 = Nurse Practitioner or Physician's Assistant [hospiceVst1Who]	64-68 **a2.** [ ][ ][ ][ ][ ] min. *(Write the length of time in box. If less than 5 digits, please place zeros in the appropriate boxes.)* [hospiceVst1Time]
b1. 69 [ ] *(Select the appropriate answer from the list below and write one number in the box.)* 1 = Chaplain 2 = Home Health Aid 3 = Nurse 4 = Physician 5 = Social Worker 6 = Volunteer 7 = Other: _____ 8 = Nurse Practitioner or Physician's Assistant [hospiceVst2Who]	70-74 **b2.** [ ][ ][ ][ ][ ] min. *(Write the length of time in box. If less than 5 digits, please place zeros in the appropriate boxes.)* [hospiceVst2Time]
c1. 75 [ ] *(Select the appropriate answer from the list below and write one number in the box.)* 1 = Chaplain 2 = Home Health Aid 3 = Nurse 4 = Physician 5 = Social Worker 6 = Volunteer 7 = Other: _____ 8 = Nurse Practitioner or Physician's Assistant [hospiceVst3Who]	76-80 **c2.** [ ][ ][ ][ ][ ] min. *(Write the length of time in box. If less than 5 digits, please place zeros in the appropriate boxes.)* [hospiceVst3Time]

Patient ID: 1-5 [ ][ ] - [subject] **Patient Initials:** 6-8 [ ][ ][ ] **Visit No:** 9 [ ] (1 = Visit 1 (baseline), 2 = Visit 2, 3 = Visit 3, 4 = Visit 4 (final)) [visit] **Form No:** 10-11 1 0 [form]

4. **Documentation of "Usual Care"- CONTINUED:** *In the table below, please record the type and length of contact for ALL visits with the patient over the past week. Please mark one type of visit per row. Please do NOT record study-related data collection or touch therapy visits.*

Discipline	Length of time *(minutes)*
d1. 81 [ ] *(Select the appropriate answer from the list below and write one number in the box.)* 1 = Chaplain 2 = Home Health Aid 3 = Nurse 4 = Physician 5 = Social Worker 6 = Volunteer 7 = Other: _____ 8 = Nurse Practitioner or Physician's Assistant [hospiceVst4Who]	**d2.** 82-86 [ ][ ][ ][ ][ ] min. *(Write the length of time in box. If less than 5 digits, please place zeros in the appropriate boxes.)* [hospiceVst4Time]
e1. 87 [ ] *(Select the appropriate answer from the list below and write one number in the box.)* 1 = Chaplain 2 = Home Health Aid 3 = Nurse 4 = Physician 5 = Social Worker 6 = Volunteer 7 = Other: _____ 8 = Nurse Practitioner or Physician's Assistant [hospiceVst5Who]	**e2.** 88-92 [ ][ ][ ][ ][ ] min. *(Write the length of time in box. If less than 5 digits, please place zeros in the appropriate boxes.)* [hospiceVst5Time]
f1. 93 [ ] *(Select the appropriate answer from the list below and write one number in the box.)* 1 = Chaplain 2 = Home Health Aid 3 = Nurse 4 = Physician 5 = Social Worker 6 = Volunteer 7 = Other: _____ 8 = Nurse Practitioner or Physician's Assistant [hospiceVst6Who]	**f2.** 94-98 [ ][ ][ ][ ][ ] min. *(Write the length of time in box. If less than 5 digits, please place zeros in the appropriate boxes.)* [hospiceVst6Time]

REDUCING END-of-LIFE SYMPTOMS WITH TOUCH (REST)

Treatment Form (FORM 11)

Instructions: This form should be completed by the Moving Touch Therapist or Non-Moving Touch Volunteer for each randomized patient according to the following schedule:

Treatment Visit 1 within 3 working days of the Baseline Data Collection Visit Date or Randomization Assignment Date; Visits 2-6 within 2 work weeks (10 working days) of the 1st Treatment Visit. The On-Site Study Coordinator will be in touch with you to inform you which date to base your scheduling on. Please inform the OSSC ASAP after the Last Treatment Visit has occurred.

If patient's level of consciousness is "Comatose" or "Somnolent", DO NOT PERFORM TREATMENT - fill out Form 13 Missed Visit Form.

Patient ID: 1-5 [ ][ ] - [subject] **Patient Initials:** 6-8 [ ][ ][ ] **Visit No:** 9 [ ] (1 = Visit 1, 2 = Visit 2, 3 = Visit 3, 4 = Visit 4, 5 = Visit 5, 6 = Visit 6) [visit] **Form No:** 10-11 [1][1] [form]

---

1. Date of treatment: 12-19 [ ][ ] MM [ ][ ] DD [ ][ ][ ][ ] Year

Removed due to PHI please see var [daysRandTreatment] for number of days between randomization and date of form.

2. Patient location: 20 [ ] (Write Number in box)
   1 = Home
   2 = Nursing Home/Skilled Nursing Facility
   3 = Hospice Facility
   4 = Other, specify:_____

[ploc]

3. Initial Assessment by Treatment Provider:

   a. Patient's General Appearance *(Describe - note any significant observations related to skin color, lesions, redness, dressings, ports, catheters, tubes, edema)*:_____

   Not available in dataset

   b. Patient Positioning *(Describe the patient's ability to turn and his/her most comfortable position)*:_____

   Not available in dataset

   c. Significant Patient Comments prior to Therapy Session: *(Note any comments related to areas of pain, discomfort, symptoms, ability to tolerate touch)*_____

   Not available in dataset

   d. Did patient receive massage from someone else since last therapy session? 21 [1] Yes [0] No [outsideMT]

   If "YES", date: 22-29 [ ][ ] MM [ ][ ] DD [ ][ ][ ][ ] Year

   Removed due to PHI please see var [daysOutsideMTTreat] for number of days between outside massage therapy and date of form.

30 [ ] ****Complete the modified Memorial Pain Assessment Card (Form 12) prior to the therapy session and attach**** [mpacBefore]

   e. Check box for each of the following that are completed:

   31 [ ] Explain treatment procedure [prepExplain]
   32 [ ] Obtain assent for therapy [prepAssent]
   33 [ ] Create quiet environment [prepQuiet]
   34 [ ] Assemble supplies, if needed [prepSupplies]
   35 [ ] Position for comfort and drape if needed [prepPosition]
   36 [ ] Center self or begin mental distraction technique [prepCenter]

REDUCING END-of-LIFE SYMPTOMS WITH TOUCH (REST)

Treatment Form | (FORM 11)

Patient ID: 1-5 ☐☐-☐☐☐ **[subject]**

Patient Initials: 6-8 ☐☐☐

Visit No: 9 ☐ (1 = Visit 1, 2 = Visit 2, 3 = Visit 3, 4 = Visit 4, 5 = Visit 5, 6 = Visit 6) **[visit]**

Form No: 10-11 1 1 **[form]**

---

f. Pulse immediately prior to hands-on portion of session *(60 seconds)*: 37-39 ☐☐☐ **[pulseBefore]**

g. Respirations immediately prior to hands-on portion of session *(60 seconds)*: 40-41 ☐☐ **[respBefore]**

h. Time beginning hands-on portion of session *(24-hour clock)*: 42-45 ☐☐:☐☐ **[timeStart]**

4. Final Assessment by Treatment Provider:

a. Time ending session *(24-hour clock)*: 46-49 ☐☐:☐☐ **[timeEnd]**

b. Pulse immediately after hands-on portion of session *(60 seconds)*: 50-52 ☐☐☐ **[pulseAfter]**

c. Respirations immediately after hands-on portion of session *(60 seconds)*: 53-54 ☐☐ **[respAfter]**

55 ☐ ****Complete the modified Memorial Pain Assessment Card (Form 12) following the therapy session and attach**** **[mpacAfter]**

5. Describe Treatment Session:

a. The environment during the hands-on portion of the session was: (*Write number in box*)

56 ☐ 1 = Very Quiet
2 = Somewhat Quiet
3 = Somewhat Noisy
4 = Very Noisy
[environment]

b. Sources of distraction during the hands-on portion of the session were *(Mark YES or NO for each)*:

		Yes	No	
1)	Ambient noise (e.g. overhead paging, alarms, etc.)	57 1	0	**[distractNoise]**
2)	People (adults or children) present:	58 1	0	**[distractPeople]**
3)	Pets present:	59 1	0	**[distractPets]**
4)	Radio on - music:	60 1	0	**[distractRadioMusic]**
5)	Radio on - talking:	61 1	0	**[distractRadioTalk]**
6)	Television on:	62 1	0	**[distractTV]**
7)	Other:_____	63 1	0	**[distractOther]**

5. *CONTINUED* - Describe Treatment Session:

c. Patient's Attire: *(Write the number of the category that best describes the patient's attire at time of the hands-on portion of the session):*

64 [ ] 1 = Fully clothed
2 = Hospital gown
3 = Light clothing (e.g. t-shirt, shorts)
4 = Pajamas or nightgown
5 = Underwear only
6 = Undressed

[attire]

d. Patient's Position: *(Indicate the positioning that is applicable to your session with the patient. For each position, indicate the approximate % of session time that the patient spent in that position):*

Position	% of Session Time in this Position
Prone (Lying on front or face down)	65-67 [ ][ ][ ] **[positionProne]**
Seated	68-70 [ ][ ][ ] **[positionSeated]**
Side	71-73 [ ][ ][ ] **[positionSide]**
Supine (Lying on back or face upward)	74-76 [ ][ ][ ] **[positionSupine]**
Other:_____	77-79 [ ][ ][ ] **[positionOther]**

REDUCING END-of-LIFE SYMPTOMS WITH TOUCH (REST)

Treatment Form | (FORM 11)

Patient ID: 1-5 [ ][ ] - [ ][ ][ ] [subject]

Patient Initials: 6-8 [ ][ ][ ]

Visit No: 10 [ ] (1 = Visit 1, 2 = Visit 2, 3 = Visit 3, 4 = Visit 4, 5 = Visit 5, 6 = Visit 6) [visit]

Form No: 11-12 [1][1] [form]

6. Description of Treatment: (*Examine the Body Diagram card included with your response card set to complete the questions below.)*

   a. *Areas of the body touched for moving touch or non-moving touch treatment (**Mark YES or NO** in the boxes below next to the list of body sections.)*

   b. *If you provided moving touch treatment, indicate the location and release of tender or trigger points. (**Mark YES or NO** in the boxes below next to the list of body sections to indicate if there was a release of tender or trigger points at that section.)*

   c. *If you provided non-moving touch treatment, indicate the approximate time in minutes that hands were held on each area (Mark time in boxes below next to the list of body sections. If you did not place hands on certain body sections, mark "00" for time in minutes at that section.)*

Body Section #	Body Section Name	Attach [Touch] at end of base variable name (6a - Touch) YES	(6a - Touch) NO	Attach [MT] at end of base variable name (6b - MT) YES	(6b - MT) NO	Attach [Time] at end of base variable name (6c - NMT) Minutes
1	[face] Face	80 [1]	[0]	81 [1]	[0]	82-83 [ ][ ]
2	[chest] Chest	84 [1]	[0]	85 [1]	[0]	86-87 [ ][ ]
3a.	[armUpR] Upper Arm - R (front & back)	88 [1]	[0]	89 [1]	[2]	90-91 [ ][ ]
3b.	[armUpL] Upper Arm - L (front & back)	92 [1]	[0]	93 [1]	[0]	94-95 [ ][ ]
4a.	[armLowR] Lower Arm - R (front & back)	96 [1]	[0]	97 [1]	[0]	98-99 [ ][ ]
4b.	[armLowL] Lower Arm - L (front & back)	100 [1]	[0]	101 [1]	[0]	102-103 [ ][ ]
5a.	[palmR] Palm of Hand - R	104 [1]	[0]	105 [1]	[0]	106-107 [ ][ ]
5b.	[palmL] Palm of Hand - L	108 [1]	[0]	109 [1]	[0]	110-111 [ ][ ]
6.	[abdomen] Abdomen	112 [1]	[0]	113 [1]	[0]	114-115 [ ][ ]
7a.	[legFrontUpR] Front of Upper Leg - R	116 [1]	[0]	117 [1]	[0]	118-119 [ ][ ]
7b.	[legFrontUpL] Front of Upper Leg - L	120 [1]	[0]	121 [1]	[0]	122-123 [ ][ ]
8a.	[legFrontLowR] Front of Lower Leg - R	124 [1]	[0]	125 [1]	[0]	126-127 [ ][ ]

Treatment Form (FORM 11)

Patient ID: 1-5 [ ][ ] - [ ][ ][ ] [subject]

Patient Initials: 6-8 [ ][ ][ ]

Visit No: 10 [ ] [visit]
1 = Visit 1
2 = Visit 2
3 = Visit 3
4 = Visit 4
5 = Visit 5
6 = Visit 6

Form No: 11-12 [1][1] [form]

Attach [Touch] at end of base variable name

Attach [MT] at end of base variable name

Attach [Time] at end of base variable name

Body Section #	Body Section Name	(6a - Touch) YES	(6a - Touch) NO	(6b - MT) YES	(6b - MT) NO	(6c - NMT) Minutes
8b.	[legFrontLowL] Front of Lower Leg - L	128 [1]	[0]	129 [1]	[0]	130-131 [ ][ ]
9a.	[footTopR] Top of Foot - R	132 [1]	[0]	133 [1]	[0]	134-135 [ ][ ]
9b.	[footTopL] Top of Foot - L	136 [1]	[0]	137 [1]	[0]	138-139 [ ][ ]
10.	[scalp] Scalp (Back of Head)	140 [1]	[0]	141 [1]	[0]	142-143 [ ][ ]
11.	Posterior Cervical (Back of Neck) [postCerv]	144 [1]	[0]	145 [1]	[0]	146-147 [ ][ ]
12.	[backUp] Shoulders / Upper Back	148 [1]	[0]	149 [1]	[0]	150-151 [ ][ ]
13.	[backMid] Mid Back	152 [1]	[0]	153 [1]	[0]	154-155 [ ][ ]
14.	[backLow] Lower Back	156 [1]	[0]	157 [1]	[0]	158-159 [ ][ ]
15a.	[handBackR] Back of Hand - R	160 [1]	[0]	161 [1]	[0]	162-163 [ ][ ]
15b.	[handBackL] Back of Hand - L	164 [1]	[0]	165 [1]	[0]	166-167 [ ][ ]
16a.	[glutR] Gluteal (Buttocks) - R	168 [1]	[0]	169 [1]	[0]	170-171 [ ][ ]
16b.	[glutL] Gluteal (Buttocks) - L	172 [1]	[0]	173 [1]	[0]	174-175 [ ][ ]
17a.	[legBackUpR] Back of Upper Leg - R	176 [1]	[0]	177 [1]	[0]	178-179 [ ][ ]
17b.	[legBackUpL] Back of Upper Leg - L	180 [1]	[0]	181 [1]	[0]	182-183 [ ][ ]
18a.	[legBackLowR] Back of Lower Leg - R	184 [1]	[0]	185 [1]	[0]	186-187 [ ][ ]
18b.	[legBackLowL] Back of Lower Leg - L	188 [1]	[0]	189 [1]	[0]	190-191 [ ][ ]
19a.	[footBottomR] Bottom of Foot - R	192 [1]	[0]	193 [1]	[0]	194-195 [ ][ ]
19b.	[footBottomL] Bottom of Foot - L	196 [1]	[0]	197 [1]	[0]	198-199 [ ][ ]

REDUCING END-of-LIFE SYMPTOMS WITH TOUCH (REST)

Treatment Form | (FORM 11)

Patient ID: 1-5 [ ][ ]-[ ][ ][ ] **[subject]**

Patient Initials: 6-8 [ ][ ][ ]

Visit No: 9 [ ] (1 = Visit 1, 2 = Visit 2, 3 = Visit 3, 4 = Visit 4, 5 = Visit 5, 6 = Visit 6) **[visit]**

Form No: 10-11 [1][1] **[form]**

7. If you provided moving touch treatment, indicate approximate *percent* of session time - Effleurage: 200-202 [ ][ ][ ]%
   [timeMTEff]

8. If you provided moving touch treatment, indicate approximate *percent* of session time - Petrissage: 203-205 [ ][ ][ ]%
   [timeMTPet]

9. Reason (if any) for early termination of treatment session: Not available in dataset

10. Significant observations or patient comments: Not available in dataset

11. Other comments observations (continue on other side and indicate with arrow, if needed): Not available in dataset

Form Completed By: _____

REDUCING END-of-LIFE SYMPTOMS WITH TOUCH (REST)

Memorial Pain Assessment Card (MPAC) | (FORM 12)

Instructions: This form should be completed by the Moving-Touch Therapist or Non-Moving Touch Volunteer for each randomized patient prior to and immediately following each moving-touch or non-moving touch session, as indicated on Form 11-Treatment Form.

Patient ID: 1-5 [ ][ ]-[ ][ ][ ] **[subject]**

Patient Initials: 6-8 [ ][ ][ ]

Visit No: 9 [ ] **[visit]**
1 = Visit 1
2 = Visit 2
3 = Visit 3
4 = Visit 4
5 = Visit 5
6 = Visit 6

Form No: 10-11 [1][2] **[form]**

12 [ ] **[prePost]**
1 = Pre-Session
2 = Post Session

---

1. Date: 13-20 [ ][ ] [ ][ ] [ ][ ][ ][ ] MM DD Year

Removed due to PHI please see var [daysRandMPAC] for number of days between randomization and date of form.

Instructions: Please record the number indicated by the patient in the boxes beside each scale.

2. Please indicate on the card the number that best describes your **pain intensity** right now.

PAIN SCALE

0 LEAST POSSIBLE PAIN — 1 — 2 — 3 — 4 — 5 — 6 — 7 — 8 — 9 — 10 WORST POSSIBLE PAIN

21-22 [ ][ ] **[mpacPain]**

3. Please indicate on the card the number that best describes your **mood** right now.

MOOD SCALE

0 WORST MOOD — 1 — 2 — 3 — 4 — 5 — 6 — 7 — 8 — 9 — 10 BEST MOOD

23-24 [ ][ ] **[mpacMood]**

Form Completed by:_____

REDUCING END-of-LIFE SYMPTOMS WITH TOUCH (REST)

Missed Visit or Therapy Form (FORM 13)

Instructions: This form should be completed by the On-Site Data Collector, Moving Touch Therapist, or Non-Moving Touch Volunteer, for each randomized patient when a visit is missed. Please turn this form in to the On-Site Study Coordinator as soon as possible following a missed visit.

Patient ID: 1-5 ☐☐ - [subject] ☐☐☐ **Patient Initials:** 6-8 ☐☐☐ **Visit No:** 9 ☐ [visit] **Form No:** 10-11 1 3 [form]

1. Date: 12-19 ☐☐ MM ☐☐ DD ☐☐☐☐ Year

Removed due to PHI please see var [daysRandMiss] for number of days between randomization and date of form.

2. Patient location: (Write Number in box) 20 ☐ [ploc]
   1 = Home
   2 = Nursing Home/Skilled Nursing Facility
   3 = Hospice Facility
   4 = Other, specify:_____

3. Reason for missed visit or therapy sesson? *(Write in one number)*

21 ☐ [missReason]
1 = Patient not in room or at home
2 = Patient refused
3 = Patient unable to participate in scheduled visit (e.g., too ill to participate, too tired to participate comatose, somnolent, or too confused).
4 = Family refused to allow patient to participate in scheduled visit
5 = Patient died
6 = Other (please specify:)_____

4. a. Missed visit was for the following session: *(Write in one number)*

[missType] 22 ☐
1 = Data collection by On-Site Data Collector
2 = Treatment session by Moving Touch Therapist or Non-Moving Touch Volunteer

If missed visit was for Baseline Data Collection,by the OSDC, the visit may be rescheduled within a maximum of 5 days beyond enrollment (the addition of 2 working days).
If for the Weekly Data Collection Visits, the visits may be rescheduled within a maximum of:
1st Weekly Visit = 7 working days beyond Baseline Data Collection
2nd Weekly Visit = 7 working days beyond 1st Weekly Visit
Final Data Collection Visit = 9 working days beyond Final Treatment Session.
*If it is past that time period, do not reschedule visits and check box *4c.*

*If missed visit was for a Treatment Session, please reschedule ASAP if you are still within the 2 work week period (10 working days) from the first treatment session. If it is past that time period, do not reschedule visits and check box *4c.*

b. Data collection or treatment session rescheduled: 23-30 ☐☐ MM ☐☐ DD ☐☐☐☐ Year

Removed due to PHI please see var [daysMissRsch] for number of days between missed visit date and rescheduled visit date.

*c. OSDC / MTT / NMTV : *(Check box)*

[noResched] 31 ☐ **Unable to reschedule because it is past the time allowed for rescheduling.**

Form Completed by:_____

REDUCING END-of-LIFE SYMPTOMS WITH TOUCH (REST)	
Serious Adverse Event (SAE)	**FORM 14**

Instructions:

The On-Site Study Coordinator (OSSC) should complete this form for each randomized patient who experiences a Serious Adverse Event (SAE), including death. Please complete a separate form for each SAE experienced by the patient.

Please call Dr. Jean Kutner at (303) 372-9086 within 24 hours of knowledge of the SAE. If she is not available, please leave a detailed message describing the incident.

Please complete and fax this form to the PoPCRN Office at 1-866-301-7268 within 48 hours of knowledge of the SAE.

The OSSC MUST report any Serious Adverse Events that are unexpected (Question 5 marked 2) and related (Question 7 marked 2-possibly, 3-probably, or 4-definitely) to one of the study treatments within the timelines and via the methods noted above if they occur during the patient's 3-to-4 week participation timeframe from the date of enrollment (signing of consent and HIPAA forms).

Events that are expected (except death) and unrelated to one of the study interventions do NOT need to be reported. These types of events are seen as part of the natural progression of the patient's disease.

All deaths, whether or not they are expected or related to the patient's participation in one of the study interventions, MUST be reported within the timelines and via the methods described above if they occur during the patient's 3-to-4 week participation timeframe from the date of enrollment (signing of consent and HIPAA forms). (This applies even if the patient has terminated from the study.)

For deaths involving actively enrolled patients and that lead to early termination of the patient from the study, please complete Form 15 (Study Termination & Mortality), in addition to Form 14. If the death occurs AFTER the patient's 3-to-4 week participation in the study, there is no need to fill out Form 14 or Form 15.

An SAE should only be categorized as a follow-up report (Question 3a marked 2 and 3b is the date of original SAE) if the current incident clearly relates to a previous incident. Otherwise, all SAEs are initial (Question 3a is 1).

- Example of Related SAEs: The first SAE was an embolism (Question 8 was marked 3) and the second SAE showed the cause of death (Questions 6d) as a pulmonary embolus (PE).
- Example of Unrelated SAEs: The first SAE was a skin tear (Question 8 was marked 7) and the second SAE showed the cause of death (Question 6d) as lung cancer.

If the SAE is categorized as a follow-up report, then it MUST be reported even if it occurs beyond the patient's anticipated 3-to-4 week participation timeframe.

Please do NOT mark the "Incident # for patient." This is for PoPCRN Office use only.

REDUCING END-of-LIFE SYMPTOMS WITH TOUCH (REST)

Serious Adverse Event (SAE) | FORM 14

Instructions: *The On-Site Study Coordinator (OSSC) should complete this form for each randomized patient who experiences a Serious Adverse Event (SAE), including death, while he/she is enrolled in the study. Please complete a separate form for each SAE experienced by the patient.*

Please call Dr. Jean Kutner at (303) 372-9086 within 24 hours of knowledge of the SAE. If she is not available, please leave a detailed message describing the incident. Please complete and fax this form to the PoPCRN Office at 1-866-301-7268 within 48 hours of knowledge of the SAE.

Please do NOT mark the "Incident # for patient." This is for PoPCRN Office use only.

Patient ID: 1-5 ____ - [subject] **Patient Initials:** 6-8 ___ **Incident # for patient:** 9 ___ [incNo] **Form No:** 10-11 1 4 [form]

1. Date: 12-19 MM DD Year

Removed due to PHI please see var [daysRandSAE] for number of days between randomization and date of form.

2. Patient location: (Write Number in box) 20 ___ [ploc]
1 = Home
2 = Nursing Home/Skilled Nursing Facility
3 = Hospice Facility
4 = Other, specify:_____

3a. Initial or Follow-up Report: *(Write number in box)*

21 ___ [reportType]
1 = Initial
2 = Follow-up - *[Only if the current SAE clearly relates to a previously reported SAE]* - *Please answer Question 3b.*

3b. Date of original SAE: 22-29 MM DD Year

Removed due to PHI please see var [daysSAEFU] for number of days between initial report and follow-up form (if this is a follow-up form).

4. Classification of SAE: *(Write number in box)*

30 ___ [saeClass]
1 = Hospitalization/prolonged hospitalization
2 = Disability
3 = Serious and/or unexpected reactions
4 = Death - [*If death occurs during the study, then please complete Form 15]*
5 = Congenital, anomaly or birth defect
6 = Life-threatening

5. Expectedness: *(Write number in box)*

31 ___ [expectedness]
1 = Expected *[If due to disease progression]*
2 = Unexpected

6a. Outcome: *(Write number in box)*

32 ___ [outcome]
1 = Resolved - *Please answer Question 6b.*
2 = Ongoing
3 = Death - [*If death occurs during the study, please complete Form 15]* - *Please answer Questions 6c and 6d.*

b. *If "Resolved", date resolved:* 33-40 MM DD Year

Removed due to PHI please see var [daysUntilResolved] for number of days between initial report and SAE resolution.

c. *If "Death", date of death:* 41-48 MM DD Year

Removed due to PHI please see var [daysUntilDeath] for number of days between initial report and death.

d. *Cause of death (Please specify exact cause):* [causeOfDeath] 49-78 _____

7. Relationship of SAE to Intervention: *(Write number in box)*

79 ___ [related]
1 = Not related
2 = Possible
3 = Probable
4 = Definitely

8. Type of SAE: *(Write number in box)*

80 ___ [saeType]
1 = Fracture
2 = Serious bruising
3 = Embolism
4 = Allergic reaction
5 = Dislodged catheter
6 = Dislocation of joints
7 = Skin tear
8 = Other, specify:_____

REDUCING END-of-LIFE SYMPTOMS WITH TOUCH (REST)

Serious Adverse Event (SAE) | FORM 14

Patient ID: 1-5 [ ][ ]-[ ][ ][ ] **Patient Initials:** 6-8 [ ][ ][ ] **Incident # for patient:** 9 [ ] **Form No:** 10-11 [1][4]

9. Attach all supporting documentation and list attachments here:

a. _____
b. _____
c. _____
d. _____

Form Completed By:_____

For PoPCRN OFFICE USE ONLY

10. If this is a death, is it possibly related to treatment and is more than 30 days after treatment?

If Yes, it must be reported to COMIRB. Report other deaths as required. 81 [1] **Yes** [2] **No**

11. Has this type of event been reported to COMIRB before? 82 [1] **Yes** [2] **No**

If YES, please list the number of times local: _____

If YES, please list the number of times off-site: _____

12. Is this SAE named in the consent form as a risk? 83 [1] **Yes** [2] **No**

If NO, should it be? (Write number in box) 84 [ ]
1 = Yes, *(submit changes with an Alteration / Update Form)*
2 = No, justify:_____

13. Do you recommend protocol changes? 85 [1] **Yes** [2] **No**

If Yes, submit changes with a Protocol Amendment Form

14. Anticipated number of subjects to be enrolled across all sites: 86-88 [ ][ ][ ]

15. Number of subjects enrolled across all sites: 89-91 [ ][ ][ ]

As of date: 92-99 [ ][ ] MM [ ][ ] DD [ ][ ][ ][ ] Year

REMINDER: If there is any new information contained in this report that might have an impact on issues of risk connected with this study, a revision must be made to the protocol and/or consent form.

Fill out the appropriate COMIRB SAE or Safety Update Form and report to COMIRB according to COMIRB rules.

At the PoPCRN Office, form completed by:_____

REDUCING END-of-LIFE SYMPTOMS WITH TOUCH (REST)

Study Termination & Mortality Form | (FORM 15)

Instructions: This form should be completed by the On-Site Study Coordinator whenever a randomized patient terminates participation in the study prematurely or dies. If the patient has suffered an adverse event or died, please notify the Project Manager at PoPCRN as soon as possible. Please complete Form 14-Serious Adverse Event Form.

Patient ID: 1-5 [ ][ ] - [subject] [ ][ ][ ] **Patient Initials:** 6-8 [ ][ ][ ] **Form No:** 9-10 1 5 [form]

1. Date: 11-18 MM [ ][ ] DD [ ][ ] Year [ ][ ][ ][ ]

Removed due to PHI please see var [daysRandTerm] for number of days between randomization and form date.

2. Patient location: 19 [ ] (Write Number in box) [ploc]
1 = Home
2 = Nursing Home/Skilled Nursing Facility
3 = Hospice Facility
4 = Other, specify:_____

3. Patient terminates prematurely from study alive? **a.** 20 [1] **Yes** [0] **No** *(If NO, skip to Question 4)*

If yes, reason for terminating prematurely from study: (MarkYES or NO)		YES	N0	
				[preTermAlive]
b. Patient refuses to continue participation: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _	21	1	0	[ptRefuse]
c. Patient's family requested withdrawal of patient from study:_ _ _ _ _ _ _ _ _	22	1	0	[famRefuse]
d. Patient's physician/medical caregivers requested withdrawal of patient from study:	23	1	0	[provRefuse]
e. Adverse event requires withdrawal of patient from study:_ _ _ _ _ _ _ _ _ _	24	1	0	[aeWithdrawal]
f. Patient no longer able to participate due to cognitive impairment:_ _ _ _ _ _ _	25	1	0	[cogImpair]
g. Patient no longer able to participate due to other symptoms or normal progression of disease: _	26	1	0	[dzProgress]
h. Patient discharged alive and unable to continue participation:_ _ _ _ _ _ _ _	27	1	0	[dischAliveUnable]
i. Patient discharged alive and but unwilling to continue participation in the study:_ _	28	1	0	[dischAliveUnwilling]
j. Other (specify):_____	29	1	0	[reasonOther]

4. Patient has died: **a.** 30 [1] **Yes** [0] **No** [died]

b. If YES, date of death: 31-38 MM [ ][ ] DD [ ][ ] Year [ ][ ][ ][ ]

Removed due to PHI please see var [daysRandDeath] for number of days between randomization and death date.

c. If YES, cause of death: [causeOfDeath] 39-68 _____

_____

_____

If patient has died, please fill out Form 14 (Serious Adverse Event Form) immediately and follow it's instructions.

Form Completed by:_____