RACER

Participant Trial Number:

Site Code:

Collection Method (Tick):

Telephone In-person Post

3 Month Questionnaire

We would like to know about your: **Right knee** ☐

Left knee ☐

Please answer ALL of these questions with regard to the knee that was treated in the study, this is ticked above

Please read **ALL** the instructions carefully before completing the questionnaire.

Please use **BLACK** or **BLUE PEN** to complete the questionnaire.

Please **DO NOT** sign or add your name to this questionnaire.

Please **CHECK** that **ALL** the questions have been answered after you finish.

Please tell us the date you filled out this questionnaire: d d – m o n – y y y y

Funder acknowledgement:

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SECTION A: KNEE QUESTIONNAIRE

A healthy joint is not something you are aware of in everyday life. However, even the smallest problems can raise one's awareness of a joint. This means that you think of your joint or have your attention drawn to it. The following questions concern how often you are aware of your affected knee joint in everyday life. Please choose the most appropriate answer for each question.

Are you aware of your knee joint...	Never	Almost never	Seldom	Sometimes	Mostly
1. … in bed at night?	☐	☐	☐	☐	☐
2. … when you are sitting on a chair for more than one hour?	☐	☐	☐	☐	☐
3. … when you are walking for more than 15 minutes?	☐	☐	☐	☐	☐
4. … when you are taking a bath/shower?	☐	☐	☐	☐	☐
5. … when you are traveling in a car?	☐	☐	☐	☐	☐
6. … when you are climbing stairs?	☐	☐	☐	☐	☐
7. … when you are walking on uneven ground?	☐	☐	☐	☐	☐
8. … when you are standing up from a low sitting position?	☐	☐	☐	☐	☐
9. … when you are standing for long periods of time?	☐	☐	☐	☐	☐
10. … when you are doing house-work or gardening?	☐	☐	☐	☐	☐
11. … when you are taking a walk/hiking?	☐	☐	☐	☐	☐
12. … when you are doing your favourite sport?	☐	☐	☐	☐	☐

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SECTION B: QUALITY OF LIFE

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

Mobility

I have no problems in walking about ☐
I have slight problems in walking about ☐
I have moderate problems in walking about ☐
I have severe problems in walking about ☐
I am unable to walk about ☐

Self Care

I have no problems with washing or dressing myself ☐
I have slight problems with washing or dressing myself ☐
I have moderate problems washing or dressing myself ☐
I have severe problems with washing or dressing myself ☐
I am unable to wash or dress myself ☐

Usual Activities (e.g. work, study, housework, family or leisure activities)

I have no problem doing my usual activities ☐
I have a slight problem doing my usual activities ☐
I have moderate problems doing my usual activities ☐
I have severe problems doing my usual activities ☐
I am unable to do my usual activities ☐

Pain/Discomfort

I have no pain or discomfort ☐
I have slight pain or discomfort ☐
I have moderate pain or discomfort ☐
I have severe pain or discomfort ☐
I have extreme pain or discomfort ☐

Anxiety/Depression

I am not anxious or depressed ☐
I am slightly anxious or depressed ☐
I am moderately anxious or depressed ☐
I am severely anxious or depressed ☐
I am extremely anxious or depressed ☐

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

The best health you can imagine

The worst health you can imagine

PROBLEMS WITH YOUR KNEE

Tick (✓) one box for every question.

1. During the past 4 weeks…

How would you describe the pain you usually have from your knee?

None	Very mild	Mild	Moderate	Severe
☐	☐	☐	☐	☐

2. During the past 4 weeks…

Have you had any trouble with washing and drying yourself (all over) because of your knee?

No trouble at all	Very little trouble	Moderate trouble	Extreme difficulty	Impossible to do
☐	☐	☐	☐	☐

3. During the past 4 weeks…

Have you had any trouble getting in and out of a car or using public transport because of your knee? (whichever you tend to use)

No trouble at all	Very little trouble	Moderate trouble	Extreme difficulty	Impossible to do
☐	☐	☐	☐	☐

4. During the past 4 weeks…

For how long have you been able to walk before pain from your knee becomes **severe**? (with or without a stick)

No pain/More than 30 minutes	16 to 30 minutes	5 to 15 minutes	Around the house only	Not at all/pain severe when walking
☐	☐	☐	☐	☐

5. During the past 4 weeks…

After a meal (sat at a table), how painful has it been for you to stand up from a chair because of your knee?

Not at all painful	Slightly painful	Moderately painful	Very painful	Unbearable
☐	☐	☐	☐	☐

6. During the past 4 weeks…

Have you been limping when walking, because of your knee?

Rarely/ never	Sometimes, or just at first	Often, not just at first	Most of the time	All of the time
☐	☐	☐	☐	☐

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7. During the past 4 weeks…

Could you kneel down and get up again afterwards?

Yes, easily	With little difficulty	With moderate difficulty	With extreme difficulty	No, impossible
☐	☐	☐	☐	☐

8. During the past 4 weeks…

Have you been troubled by pain from your knee in bed at night?

No nights	Only 1 or 2 nights	Some nights	Most nights	Every night
☐	☐	☐	☐	☐

9. During the past 4 weeks…

How much has pain from your knee interfered with your usual work (including housework)?

Not at all	A little bit	Moderately	Greatly	Totally
☐	☐	☐	☐	☐

10. During the past 4 weeks…

Have you felt that your knee might suddenly 'give way' or let you down?

Rarely/ never	Sometimes, or just at first	Often, not just at first	Most of the time	All of the time
☐	☐	☐	☐	☐

11. During the past 4 weeks…

Could you do the household shopping on your own?

Yes, easily	With little difficulty	With moderate difficulty	With extreme difficulty	No, impossible
☐	☐	☐	☐	☐

12. During the past 4 weeks…

Could you walk down one flight of stairs?

Yes, easily	With little difficulty	With moderate difficulty	With extreme difficulty	No, impossible
☐	☐	☐	☐	☐

Finally, please check back that you have answered each question.
Thank you very much.

ACTIVITY & PARTICIPATION QUESTIONNAIRE

PLEASE TICK (✓) ONE BOX FOR EACH STATEMENT.

Please consider these statements thinking about the past 4 weeks:	Strongly agree	Tend to agree	Neither agree nor disagree	Tend to disagree	Strongly disagree
1. It is a problem for me to do activities (e.g. sports, dancing, walking) **to the level I want, because of my knee.**	☐	☐	☐	☐	☐
2. It is a problem for me to carry heavy things (e.g. items at work, shopping, or a child)**, because of my knee.**	☐	☐	☐	☐	☐
3. I need to modify my work or everyday activities, because of my knee.	☐	☐	☐	☐	☐
4. I need to plan carefully before going out for the day because of my knee (e.g. taking painkillers, using a knee brace or checking that there will be places to sit down)**.**	☐	☐	☐	☐	☐
5. It is a problem for me to fully take part in activities with friends and family, because of my knee.	☐	☐	☐	☐	☐
6. It is a problem for me to walk at the pace I would like, because of my knee.	☐	☐	☐	☐	☐
7. It is a problem for me to twist or turn, as my knee may give way or be painful.	☐	☐	☐	☐	☐
8. It is a problem for me that I need to take longer to do everyday activities, because of my knee.	☐	☐	☐	☐	☐

Finally, please check back that you have answered each question.

Thank you very much.

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SECTION E: KNEE PAIN

Please respond to each question by marking one box per row.

During the past 7 days…	**Had no pain**	**Mild**	**Moderate**	**Severe**	**Very severe**
1. How intense was your pain at its worst?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
2. How intense was your average pain?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
	No pain	**Mild**	**Moderate**	**Severe**	**Very severe**
3. What is your level of pain right now?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

SECTION F: CHANGES IN YOUR KNEE

1. How satisfied you are with your knee replacement? **(Please tick one box only)**

- Very satisfied ☐
- Satisfied ☐
- Neither satisfied nor dissatisfied ☐
- Dissatisfied ☐
- Very dissatisfied ☐

2. **Since your operation,** how would you describe the change (if any) in activity limitations, symptoms, emotions and overall quality of life, related to your painful condition ? **(Tick one box only)**

- No change (or condition has got worse) ☐
- Almost the same, hardly any change at all ☐
- A little better, but no noticeable change ☐
- Somewhat better, but the change has not made any real difference ☐
- Moderately better, and slight but noticeable change ☐
- Better, and a definite improvement that has made a real and worthwhile difference ☐
- A great deal better, and a considerable improvement that has made all the difference ☐

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SECTION G: PROBLEMS AND COMPLICATIONS

Since your operation:

1. Have you had a re-operation or revision of your knee replacement? Yes ☐ No ☐

   If **YES**, please give details below:

2. Have you had any other treatment or surgery to your knee, apart from the operation you had as part of the study? Yes ☐ No ☐

   If **YES**, please give details below:

3. Have you had any other injuries to the your knee? Yes ☐ No ☐

   If **YES**, please give details below

4. Have you had an infection of your knee? Yes ☐ No ☐

   If **YES**, were you given antibiotics orally, through a vein, or both? Please give details below:

5. Have you been diagnosed with a deep vein thrombosis (DVT) or pulmonary embolism (PE)? Yes ☐ No ☐

   If **YES**, please give details below:

SECTION H: PAINKILLERS AND ANALGESIA

In this section, we would like to know *how much* of different *pain-killing* drugs you are using for your *knee* on a typical day **over the past 4 weeks**. If you are not taking any pain-killing drugs for your knee, please mark the "No" box below.

1. Are you taking any painkillers or analgesia medicine for your knee in the study?

☐ **Yes**, please complete the below tables ☐ **No**, please go to **SECTION I**

Common painkillers or analgesia tablets you may be using could include:	
• Paracetamol (soluble or tablets) • Anti-Inflammatory (Ibuprofen, Naproxen, Diclofenac, Celecoxib etc.) • Co-codamol (Zapain, Solpadol, Tylenol etc.) • Tramadol	• Oxycodone/Oxynorm, • Morphine Sulphate Tablets (MST, Morphogesic, Zomorph, Sevredol, MXL etc.) • Gabapentin • Pregabalin
If you do not know exactly how much medication you have been having, please give us your best guess.	

Table 1: TABLETS

Name of Medication *Please write the medication name in the blank lines, some examples have been provided in the table above.*	**Strength of Tablet** *Please include units (e.g. mg or 8/500 etc.)*	**Thinking about the last 4 weeks, on a typical day how many tablets did you take in total, per day?** *For example, if you typically took 2 tablets four times during the day, then write "8" below.*
Example: Paracetamol	*500mg*	*8*

Table 2: LIQUID *(a usual dose is 5mls = one teaspoon or 10mls = two teaspoons etc.)*		
Name of Medication *Please write the medication name in the blank lines*	**Strength of Medication** *Please include units (e.g. mls, teaspoons etc.)*	**Thinking about the last 4 weeks, on a typical day how many teaspoons did you take in total, per day?** *(for example, if you take 1 teaspoon (5ml) four times a day, write "4")*
Example: Morphine liquid (or Oramorph)	5ml or 1 teaspoon	4

Table 3: PATCHES		
Name of Medication *Please write the medication name in the blank lines*	**Strength of Medication** *Please include units (e.g. mcg)*	**Thinking about the last 4 weeks, how many patches have you used?** *Please write number*
Example: Morphine patch (Fentanyl patch)	75 mcg	2

SECTION I: USING THE NHS

Please think back over the times that you have used the NHS **since your operation**. If you are unsure about any answer, please write in your best recollection.

Inpatient care

1. **Since your operation**, have you been admitted to hospital because of your operated knee?

☐ **Yes**, please complete the below table ☐ **No**, please go to **QUESTION 2**

Please tell us which department of the hospital you went to (speciality) and the number of admissions you had to hospital. If the speciality is not listed, then please write in the reason or part of your body as best you can. You can record multiple admissions in the boxes below.

Speciality	Reason/Procedure	Number of admissions
Orthopaedics for your knee (other than the planned operation for the study)		
Orthopaedics for any other bones		
Rehabilitation unit		
For any other surgery? Details: …… ……		
For any other non-surgical reason? Details: …… ……		

Outpatient care

2. Since your operation, have you made any visits to the hospital or a clinic as an **outpatient**?

☐ **Yes**, please complete the below table ☐ **No**, please go to **QUESTION 3**

Please indicate which part of the hospital you went to (speciality). If you don't know which speciality it was, or if it's not listed, then write in the reason or part of your body as best you can.

Please report the number of consultations (where appropriate). This may include online, telephone or face-to-face consultations.

Speciality	Examples	Number of visits/ consultations
Orthopaedics	Seeing a surgeon about your knee, changes to plaster or aids (e.g. sling)	
Pathology	For blood tests	
Radiology	For 1. X-rays 2. MRI scan 3. CT scan	X-rays: MRI scan: CT scan:
Emergency Department	Related to your knee or surgery wound	
Emergency Department	Any other reason (e.g. Blood clot in the leg or lung)	
Other: (please provide details here)		

Community Health care

3. Since your operation, have you seen any **health professionals** in the community **because of your knee?**

☐ **Yes**, please complete the below table ☐ **No**, please go to **QUESTION 4**

Please indicate the type of professional and total number of consultations (including online, telephone or face-to-face consultations or any combination of these). If the professional isn't listed, then feel free to write this in "Other community health professionals".

Type of professional	Total number of consultations
GP	
Nurse	
District Nurse	
Occupational Therapist	
Other community health professionals *(Please specify here):*	

Personal social services

4. Since your operation, have you been provided with **personal social services** to make your day to day life easier to manage?

☐ **Yes**, please complete the below table ☐ **No**, please go to **QUESTION 5**

If **YES**, in the below table please indicate the number of days/contacts with the services below in the same period of time. If the type of support you have received isn't listed, then feel free to write this in "Other".

A. Did you receive meals on wheels? ☐ Yes ☐ No

If **YES**, how many times on average in the week did you receive meals on wheels? Please also specify if these were hot or frozen meals.

Meals on wheels (frozen, daily)	Number of days:
Meals on wheels (hot, daily)	Number of days:

B. Thinking about the **past 3 months** since your operation, did you have any contact with the below service or services?

☐ Yes ☐ No

If **YES**, how many contacts did you have with each of these services? *If none, please specify 0.*

Laundry services	Number of contacts:
Social worker contacts	Number of contacts:
Care worker contacts, including help at home	Number of contacts:
Other social services (please specify):	Number of contacts:
Other (please specify):	Number of contacts:

5. About your work

A. Are you currently in either paid or unpaid work (including carer, unpaid carer)? Yes ☐ No ☐

B. **Since your operation**, have you taken time off work or lost any income because of knee problems? Yes ☐ No ☐

(This includes time off from paid or unpaid work such as caring for children or relatives)

If **YES,** please provide number of days off work in this box ☐ **Days**

SECTION J: REHABILITATION

1. **Since your operation,** have you attended or had any physiotherapy for your knee?

☐ **No, I did not have physiotherapy -** please go to **SECTION K**

☐ **Yes, I had physiotherapy sessions** - please complete the following questions.

For the below questions please state number of sessions or write "0" if not applicable in the appropriate box below.

A. How many face-to-face sessions in the hospital outpatient department did you have?	
B. How many face-to-face sessions in the community/GP Surgery did you have?	
C. How many video or web-based consultations did you have?	
D. How many telephone consultations did you have?	
E. How many physiotherapy sessions did you have when the physiotherapist visited you at home?	

SECTION K: COVID-19

The COVID-19 pandemic has affected many people worldwide and we would like to know how many have been affected in this trial:

A. Do you think you have had COVID-19? ☐ No ☐ Yes

B. If **YES,** and you think you have had COVID-19, was this confirmed with a test? ☐ No ☐ Yes

SECTION L: MOBILE APP

Would you like to complete your future follow-up questionnaires using a mobile app? ☐ No ☐ Yes

Thank you for completing this questionnaire.

If you are likely to change your contact details in the next three months, please fill out the “Change of Contact Details Form” on the following page.

Please return this booklet to the RACER Trial Office in the Freepost envelope provided.

Change to Patient Contact Details

Site Code: | | | | **Participant TNO:** | | | | | |

Please let us know about any changes to your contact details, or your additional contacts, please complete the below form and return with your completed questionnaire or contact RACER@warwick.ac.uk

Please note that we will use all contact information you provide to attempt to reach you, unless you specify otherwise.

Your Contact Details:

Date changes effective from: d d - m o n - y y y y

Title: | First Name: | Surname:

1st Line of Address :

2nd Line of Address:

Town/City: | Postcode:

Telephone: | Mobile:

Email: | Preferred time of contact:

To help us stay in touch with you for the duration of the study, please could you to provide us with updated additional contacts. We will only make contact with these people if we cannot reach you directly. You only need to update these details if the information previously provided is now incorrect.

Please only provide contact information which you have prior permission to share with us.

Additional Contact 1:

Title:

First Name:

Surname:

Email:

Telephone:

Mobile:

Relationship:

Additional Contact 2:

Title:

First Name:

Surname:

Email:

Telephone:

Mobile:

Relationship:

GP Details: *(If changed since entering the Trial)*

Doctors Surgery Name:

Address:

For information on how your, and your additional contacts, identifiable information is handled please contact the RACER Team on the above email address or visit the trial website: https://warwick.ac.uk/fac/sci/med/research/ctu/trials/current/racer/