Paramedic Analgesia Comparing Ketamine and Morphine in trauma

Health Resource Use

3 Month Questionnaire Booklet

Participant trial number | | | | | | |

Participant initials | | | |

Date of completion D D - M M M - Y Y Y Y

When you were enrolled into the PACKMaN study you kindly agreed to complete a questionnaire, this is an important part of the study and we would be very grateful if you would complete and return the following in the pre-paid envelope provided. Alternatively, if you would like to complete this over the telephone with a member of the research team or would like a copy via email, please call 02476 150478.

The questionnaire contains information about the services you have used for any reason related to your injury since leaving hospital. This includes health care use, the expenses incurred to yourself, and any help or support provided by your family and friends.

Some questions will seem more relevant than others, please try to answer all the questions if possible. If you are unsure about any answers then please include as much as you can remember.

Your time taken to complete this questionnaire is very much appreciated, many thanks from the PACKMaN study team.

Participant study number

Participant Initials

1. Inpatient Care

1.1 Since coming home from hospital following your injury, have you been readmitted to hospital for any reason related to your initial injury?

Yes ☐ No ☐

1.2 If **yes**, please provide details of each hospital admission in the table below:

Name of hospital *(For example: Queen Elizabeth Hospital Birmingham)*	**Type of ward** *(Some examples of wards: general medical ward, ICU, HDU, psychiatric ward)*	**Total length of stay** *(For example: 3 nights)*
		nights
		nights
		nights
		nights

2. Outpatient Care

2.1 Since coming home from hospital following your injury, have you made any visits to hospitals or clinics related to your initial injury as an outpatient?

Yes ☐ No ☐

2.2 If **yes**, please provide details in the table below. If the clinic or specialty is not listed, please feel free to write this in.

Type of service or clinic	**Have you used this service?** ***(Please circle)***	**Number of visits**
Pain clinic	YES / NO	visits
Other outpatient clinic	YES / NO	visits
MRI scan	YES / NO	visits
CT scan	YES / NO	visits
X-ray	YES / NO	visits
Ultrasound	YES / NO	visits
Hospital A&E	YES / NO	visits
Other service Please provide details ……..		visits
Other service Please provide details ……..		visits

Participant study number

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3. Community health and social care

3.1 **Since coming home from hospital following your injury have you been in contact with any other health or social care professionals in the community for any reason related to your initial injury?** *For example, a GP surgery visit to discuss your ongoing pain medication.*

Yes ☐ No ☐

3.2 If **yes**, please indicate the person you saw and how often you saw them. If the person is not listed then feel free to write this in.

	Have you used this service?		Number of visits/ telephone contacts
	Yes	No	
GP surgery visit			
GP home visit			
GP telephone consultation			
GP video/online consultation			
District Nurse			
Social Worker			
Physiotherapist			
Occupational therapist			
Counsellor			
Psychologist			
Home help/ care worker			
Other: Please provide details below:			
Other Please provide details below:			
Other Please provide details below:			

Participant study number | | | | | | |

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4. Medication

4.1 Since coming home from hospital following your injury, have you been prescribed or bought over the counter any medication related to your initial injury? *For example, paracetamol to treat pain following your injury, or sertraline to treat anxiety resulting from your injury.*

Yes ☐ No ☐

4.2 If **yes**, please fill in the details in the table below. Paracetamol is given as an example of how we would like you to complete the table. You may find it helpful to look on the packaging of your medication for some of the details.

Medication	Do you take the medication continuously?	If no, how many days used?	On prescription?
Paracetamol 250mg	*YES/NO*	*8 days*	*No*

Participant study number | | | | | | |

Participant Initials | | | |

5. Special Equipment or aids

5.1 Have you used any special equipment or aids provided by health or social services or other providers to help you with your injury since coming home from hospital following your injury? *For example, wheelchair or stair handrails*

Yes ☐ No ☐

5.2 If **yes**, please describe below the equipment or aids provided to you, and any costs incurred for their use.

Description of equipment or aid used	**Who provided it? (e.g. health services, social services, self)**	**Cost to you (if none, please write '0')**
		£
		£
		£

6. Additional Information

6.1 Since coming home from hospital following your injury, have you or your partner, relatives and friends incurred any additional costs because of your injury (either planned or unplanned)?

Yes ☐ No ☐

6.2 If **yes**, please provide details in the following table:

Additional Costs	Have you incurred this form of additional cost to attend health/social care appointments?	Cost to you (if none, please write '0')	Cost to partner/ relatives/ friends (if none, please write '0')
Travel costs (e.g. bus fares)	YES / NO	£	£
Child care costs	YES / NO	£	£
Income lost*	YES / NO	£	£
Cost of help with housework	YES / NO	£	£
Cost of laundry services	YES / NO	£	£
Other: Please specify: ……			
Other: Please specify: ……			
Other: Please specify: ……			

*Please do not record if annual or compassionate leave was taken or the time taken off work was made up at a later point.

1903

Date: ☐☐ / ☐☐ / ☐☐
(month) (day) (year)

Subject's Initials : _____

Study Subject #: ☐☐☐☐

Study Name: _____

_____

Protocol #: _____

PI: _____

Revision: 07/01/05

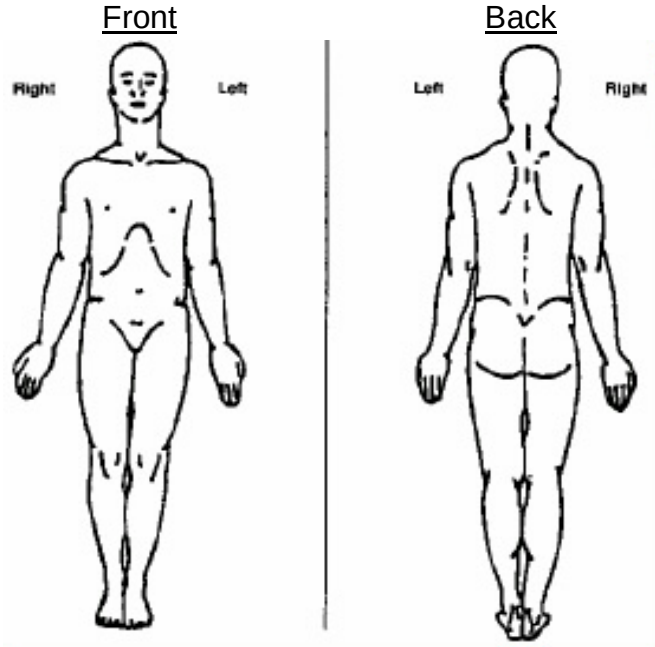
PLEASE USE BLACK INK PEN

Brief Pain Inventory (Short Form)

1. Throughout our lives, most of us have had pain from time to time (such as minor headaches, sprains, and toothaches). Have you had pain other than these everyday kinds of pain today?

☐ Yes ☐ No

2. On the diagram, shade in the areas where you feel pain. Put an X on the area that hurts the most.



3. Please rate your pain by marking the box beside the number that best describes your pain at its worst in the last 24 hours.

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

No Pain — Pain As Bad As You Can Imagine

4. Please rate your pain by marking the box beside the number that best describes your pain at its least in the last 24 hours.

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

No Pain — Pain As Bad As You Can Imagine

5. Please rate your pain by marking the box beside the number that best describes your pain on the average.

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

No Pain — Pain As Bad As You Can Imagine

6. Please rate your pain by marking the box beside the number that tells how much pain you have right now.

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

No Pain — Pain As Bad As You Can Imagine

1903

Date: ☐☐ / ☐☐ / ☐☐
(month) (day) (year)

Subject's Initials : _____

Study Subject #: ☐☐☐☐

Study Name: _____

Protocol #: _____

PI: _____

Revision: 07/01/05

PLEASE USE BLACK INK PEN

7. What treatments or medications are you receiving for your pain?

8. In the last 24 hours, how much relief have pain treatments or medications provided? Please mark the box below the percentage that most shows how much relief you have received.

0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
☐ No Relief	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐ Complete Relief

9. Mark the box beside the number that describes how, during the past 24 hours, pain has interfered with your:

A. General Activity

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Does Not Interfere — Completely Interferes

B. Mood

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Does Not Interfere — Completely Interferes

C. Walking ability

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Does Not Interfere — Completely Interferes

D. Normal Work (includes both work outside the home and housework)

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Does Not Interfere — Completely Interferes

E. Relations with other people

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Does Not Interfere — Completely Interferes

F. Sleep

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Does Not Interfere — Completely Interferes

G. Enjoyment of life

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Does Not Interfere — Completely Interferes

EQ-5D-5L

Health Questionnaire

English version for the UK

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

MOBILITY

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

SELF-CARE

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

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

I have no problems doing my usual activities ❑
I have slight problems doing my usual activities ❑
I have moderate problems doing my usual activities ❑
I have severe problems doing my usual activities ❑
I am unable to do my usual activities ❑

PAIN / DISCOMFORT

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

ANXIETY / DEPRESSION

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

- 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.
- Please mark an X on the scale to indicate how your health is TODAY.
- Now, write the number you marked on the scale in the box below.

YOUR HEALTH TODAY = ☐