

TNO:

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# Hospital Discharge Form

## HOSPITAL DISCHARGE INFORMATION – TRIAL HOSPITAL

Date and time of discharge  
from trial hospital:

--	--	--	--	--	--	--	--	--	--	--	--

DD/MMM/YYYY

		:		
--	--	---	--	--

HH/MM

If discharged from hospital,  
specify location:

Home (Unsupported)

☐

Home (Supported)

☐
Care Facility / Nursing  
Home\*
☐

Rehabilitation Facility\*

☐

With a friend/family member\*

☐

N/A – patient died

☐

Other hospital

☐

Specify: \_\_\_\_\_

Other\*

☐

Specify: \_\_\_\_\_

\*Please update Identifiers form if discharge address is different to home address

TNO:

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# Hospital Discharge Form

## HOSPITAL DISCHARGE INFORMATION – FINAL HOSPITAL

Date and time of discharge  
from final hospital:

--	--	--	--	--	--	--	--

DD/MMM/YYYY

		:		
--	--	---	--	--

HH/MM

If discharged from hospital,  
specify location:

Home (Unsupported)

☐

Home (Supported)

☐
Care Facility / Nursing  
Home\*
☐

Rehabilitation Facility\*

☐

With a friend/family member\*

☐

N/A – patient died

☐

Other\*

☐

Specify: \_\_\_\_\_

\*Please update Identifiers form if discharge address is different to home address

FORM COMPLETED BY:

Name (please print):

Date completed:

--	--	--	--	--	--	--	--

DD/MMM/YYYY

Signature:

TNO:

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# Hospital Discharge Form

**PLEASE COMPLETE THIS CRF AS CLOSE AS POSSIBLE TO THE PATIENT BEING DISCHARGED FROM THE TRIAL HOSPITAL**

## FOLLOW UP INFORMATION

Date of assessment:

		/				/					
--	--	---	--	--	--	---	--	--	--	--	--

DD/MMM/YYYY

Is the person completing the hospital discharge assessment blinded to treatment allocation?

Yes ☐No ☐

Mortality status at hospital discharge:

Alive ☐Deceased ☐

## MODIFIED OXFORD HANDICAP SCALE – TRIAL HOSPITAL

Modified Oxford Handicap Scale at discharge from trial hospital (please only tick one):

No symptoms ☐Minor symptoms ☐Some restriction in lifestyle but independent ☐Dependent but not requiring constant attention ☐Fully dependent requiring attention day and night ☐Deceased ☐

## MODIFIED OXFORD HANDICAP SCALE – FINAL HOSPITAL

Modified Oxford Handicap Scale at discharge from final hospital (please only tick one):

No symptoms ☐Minor symptoms ☐Some restriction in lifestyle but independent ☐Dependent but not requiring constant attention ☐Fully dependent requiring attention day and night ☐Deceased ☐

FORM COMPLETED BY:

Name (please print):

Date completed:

		/				/					
--	--	---	--	--	--	---	--	--	--	--	--

DD/MMM/YYYY

Signature:

TNO:

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# Hospital Discharge Form

## EQ-5D – TRIAL HOSPITAL

Under each heading, please tick the ONE box that best describes the patient's health **TODAY** (*at time of discharge*)

### 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 ☐

TNO:

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# Hospital Discharge Form

We would like to know how good or bad your health is **TODAY**.

The scale is numbered from 0 to 100.

100 means the best health you can imagine.

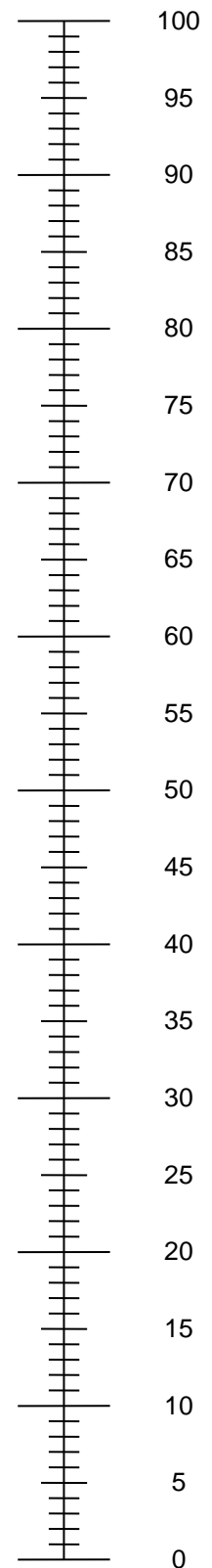
0 means the worst health you can imagine.

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

YOUR HEALTH **TODAY** =

--

The best health  
you can imagine



The worst health  
you can imagine

TNO:

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## Hospital Discharge Form

## EQ-5D – FINAL HOSPITAL

Under each heading, please tick the ONE box that best describes the patient's health **TODAY** (*at time of discharge*)

**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 ☐
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TNO:

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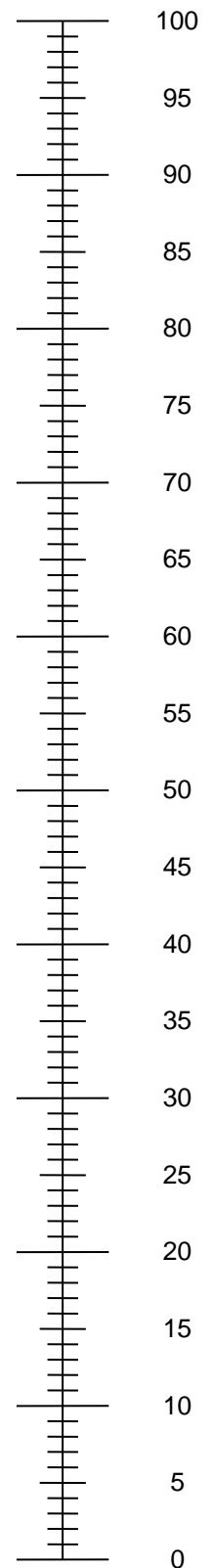
0 means the worst health you can imagine.

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- Now, please write the number you marked on the scale in the box below.

YOUR HEALTH **TODAY** =

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The best health  
you can imagine



The worst health  
you can imagine