

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:

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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 – TRIAL HOSPITAL

Date of assessment:	<table border="1"> <tr> <td></td><td></td><td></td><td></td> <td>/</td> <td></td><td></td><td></td><td></td> <td>/</td> <td></td><td></td><td></td><td></td> </tr> </table> DD/MMM/YYYY					/					/				
				/					/						
Is the person completing the hospital discharge assessment blinded to treatment allocation?	Yes <input type="checkbox"/> No <input type="checkbox"/>														
Mortality status at trial hospital discharge:	Alive <input type="checkbox"/> Deceased <input type="checkbox"/>														

FOLLOW UP INFORMATION – FINAL HOSPITAL

Date of assessment:	<table border="1"> <tr> <td></td><td></td><td></td><td></td> <td>/</td> <td></td><td></td><td></td><td></td> <td>/</td> <td></td><td></td><td></td><td></td> </tr> </table> DD/MMM/YYYY					/					/				
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Is the person completing the hospital discharge assessment blinded to treatment allocation?	Yes <input type="checkbox"/> No <input type="checkbox"/>														
Mortality status at final hospital discharge:	Alive <input type="checkbox"/> Deceased <input type="checkbox"/>														

MODIFIED OXFORD HANDICAP SCALE – TRIAL HOSPITAL

Modified Oxford Handicap Scale at discharge from trial hospital (please only tick one):	No symptoms	<input type="checkbox"/>
	Minor symptoms	<input type="checkbox"/>
	Some restriction in lifestyle but independent	<input type="checkbox"/>
	Dependent but not requiring constant attention	<input type="checkbox"/>
	Fully dependent requiring attention day and night	<input type="checkbox"/>
	Deceased	<input type="checkbox"/>

MODIFIED OXFORD HANDICAP SCALE – FINAL HOSPITAL

Modified Oxford Handicap Scale at discharge from final hospital (please only tick one):	No symptoms	<input type="checkbox"/>
	Minor symptoms	<input type="checkbox"/>
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	Fully dependent requiring attention day and night	<input type="checkbox"/>
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FORM COMPLETED BY:

Name (please		Date completed: <table border="1"> <tr> <td></td><td></td><td></td><td></td> <td>/</td> <td></td><td></td><td></td><td></td> <td>/</td> <td></td><td></td><td></td><td></td> </tr> </table> DD/MMM/YYYY					/					/				
					/					/						
Signature:																

TNO:

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Hospital Discharge Form

EQ-5D – TRIAL HOSPITAL

EQ-5D completed by:	Patient	<input type="checkbox"/>
	Patient's relative/personal legal representative	<input type="checkbox"/>
	Health care professional involved in patient's care	<input type="checkbox"/>

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:



Hospital Discharge Form

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

The scale is numbered from 0 to 100.

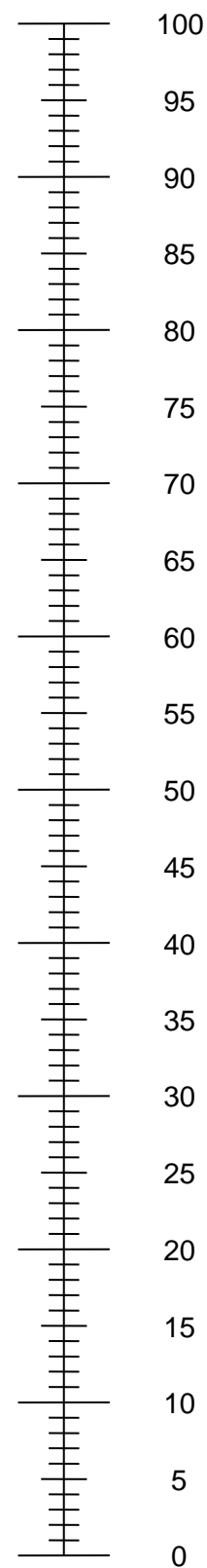
100 means the best health you can imagine.

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

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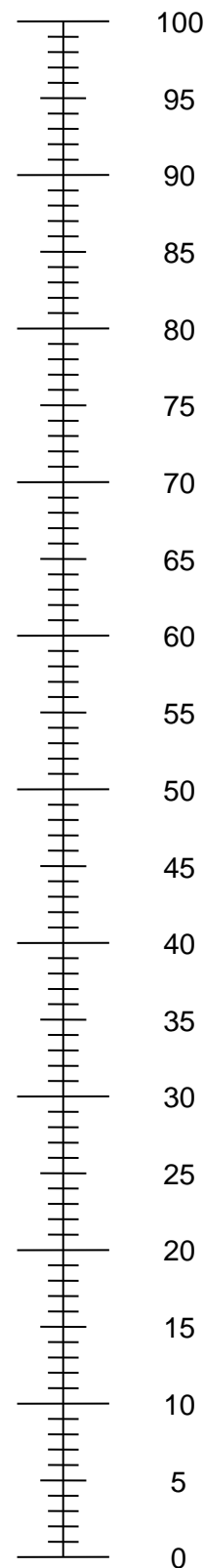
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YOUR HEALTH **TODAY** =

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The best health
you can imagine



The worst health
you can imagine