

Sugar or Salt trial:
Hyperosmolar therapy in
traumatic brain injury

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3 Month Follow-up Questionnaire

**For assistance with completing this booklet please
contact the SOS trial team on 02476 151 738**

Please read the instructions in this booklet carefully



University Hospitals Birmingham
NHS Foundation Trust



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NIHR | National Institute
for Health Research

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- Please read these instructions before completing the questionnaires.
- Please follow the instructions for each section carefully.
- Please answer **ALL** the questions. Although it may seem that the questions are asked more than once, it is still important that you answer every one.
- Please only enter **one** response for each item (unless otherwise specified).
- Please use a **BLACK** pen. Please do not use a pencil.
- Please check that you have completed all sections.
- If you make a mistake draw a single line through the incorrect entry, initial and date and add correct answer next to the incorrect entry.
- Please **DO NOT** use correction fluid

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Please let us know the date you are completing this questionnaire:

Date of completion: _____ / _____ / _____
dd mmm yyyy

Please let us know who will complete this questionnaire:

- ☐ The patient alone
- ☐ The patient with help from relative/ friend/ carer
- ☐ Relative/friend/carers on behalf of the patient

In this questionnaire, we use the words “you” and “your” referring to **the person who sustained the brain injury**. Some people in this study may have a medical condition or disability that would prevent them to fill in these questionnaires themselves. In that case, a relative/friend/ carer can fill out the questionnaires, however the words “you” and “your” still refer to **the person who sustained the brain injury** and not to the person helping/assisting in filling out the questionnaires.

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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 ☐

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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.

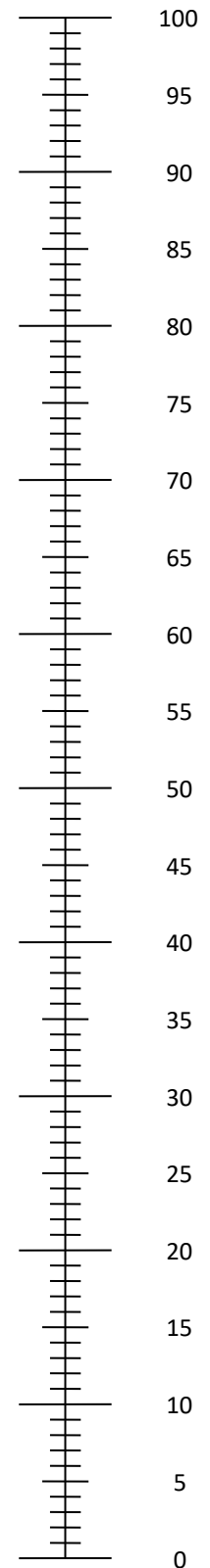
0 means the worst health you can imagine.

- 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** =

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The best health
you can imagine



The worst health
you can imagine

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Resource use questions

1. Since being discharged from hospital following your brain injury, have you used any of the following hospital based care services related to your brain injury (for example, have you been admitted to hospital again or had an outpatient clinic appointment)?

☐ If you have not yet been discharged from hospital, please tick this box and proceed to Q2.

Type of service	Have you used this service since your brain injury? Please tick (✓) yes or no	If yes, please write the total number of visits/days spent in this column
Hospital inpatient stay	No <input type="checkbox"/> Yes <input type="checkbox"/>	_____ days
Hospital outpatient clinic	No <input type="checkbox"/> Yes <input type="checkbox"/>	_____ visits
Hospital accident and emergency department	No <input type="checkbox"/> Yes <input type="checkbox"/>	_____ visits
Other (please specify)	No <input type="checkbox"/> Yes <input type="checkbox"/>	_____ visits/days (please delete as appropriate)

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2. **Since being discharged from hospital following your brain injury**, have you needed residential nursing care (e.g. step-down facilities, community ward, nursing home)?

Type of service	Have you needed this type of care since your brain injury? Please tick (✓) yes or no	If yes, how many days did you spend receiving such care?	Was this NHS funded or privately funded (either out-of-pocket or through private insurance)?
a. Community ward	No <input type="checkbox"/> Yes <input type="checkbox"/>	_____ days	NHS <input type="checkbox"/> Private <input type="checkbox"/>
b. Rehabilitation unit	No <input type="checkbox"/> Yes <input type="checkbox"/>	_____ days	NHS <input type="checkbox"/> Private <input type="checkbox"/>
c. Nursing home/care home	No <input type="checkbox"/> Yes <input type="checkbox"/>	_____ days	NHS <input type="checkbox"/> Private <input type="checkbox"/>
d. Other (please specify)	No <input type="checkbox"/> Yes <input type="checkbox"/>	_____ days	NHS <input type="checkbox"/> Private <input type="checkbox"/>

3. **Since being discharged from hospital following your brain injury**, have you used any of the following *community* based health and social services (this includes any services that are not within the hospital for example, visits to the GP)?

☐ If you have not yet been discharged from hospital, please tick this box and proceed to Q5.

Type of service	Have you used the service since your brain injury? Please tick (✓) yes or no	If yes, please write the total number of visits/contacts in this column
a. GP, surgery visit	No <input type="checkbox"/> Yes <input type="checkbox"/>	
b. GP, home visit	No <input type="checkbox"/> Yes <input type="checkbox"/>	
c. GP, telephone contact	No <input type="checkbox"/> Yes <input type="checkbox"/>	
d. GP practice nurse	No <input type="checkbox"/> Yes <input type="checkbox"/>	

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e. District nurse, health visitor or member of community health team	No <input type="checkbox"/> Yes <input type="checkbox"/>	
f. Community physiotherapist	No <input type="checkbox"/> Yes <input type="checkbox"/>	
g. Call to NHS Direct	No <input type="checkbox"/> Yes <input type="checkbox"/>	
h. Call for ambulance or paramedic	No <input type="checkbox"/> Yes <input type="checkbox"/>	
i. Occupational therapist	No <input type="checkbox"/> Yes <input type="checkbox"/>	
j. Social worker	No <input type="checkbox"/> Yes <input type="checkbox"/>	
k. Counsellor	No <input type="checkbox"/> Yes <input type="checkbox"/>	
l. Home help or care worker	No <input type="checkbox"/> Yes <input type="checkbox"/>	
m. Day centre	No <input type="checkbox"/> Yes <input type="checkbox"/>	
n. Lunch or social club (organised by health or social care providers)	No <input type="checkbox"/> Yes <input type="checkbox"/>	
o. Food, medicine or laundry delivery service (organised by health or social care providers)	No <input type="checkbox"/> Yes <input type="checkbox"/>	
p. Family or patient support or self help groups	No <input type="checkbox"/> Yes <input type="checkbox"/>	
q. Other (please specify, for example have you had any telephone consultations with your GP): 	No <input type="checkbox"/> Yes <input type="checkbox"/>	

Special Equipment or aids

4. Have you used any special equipment or aids provided by health or social services or other providers to help you since being discharged from hospital following your brain injury (e.g. wheelchair, stair handrails)?

No ☐ Yes ☐

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4.1 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')
		£
		£
		£
		£

Additional Information

5. Are you in regular work (this includes full or part-time, paid or unpaid e.g. as an unpaid carer)?

No

☐

Yes

☐

5.1 If yes, how many days were you unable to work because of health problems since your brain injury?

days

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THANK YOU FOR FILLING IN THE QUESTIONNAIRE

Please return to the study team using the pre paid envelope provided (no postage stamp required)

SOS TRIAL

Warwick Clinical Trials Unit
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Coventry, CV4 7AL.