

Block 1



3 Month Follow-up Questionnaire

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

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TNO (this can be found in the text message with the link to the questionnaire)

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

Please let us know who will complete this questionnaire:

The patient alone

The patient with help from relative/friend/carers

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

Introduction



Health Questionnaire

English version for the UK

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Mobility

Please select 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

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Self-care

Please select the ONE box that best describes your health TODAY.

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

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Usual activities

Please select the ONE box that best describes your health TODAY.

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

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Pain / Discomfort

Please select the ONE box that best describes your health TODAY.

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

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Anxiety / Depression

Please select the ONE box that best describes your health TODAY.

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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Resource Use

- We would like to know how good or bad your health is TODAY.
- You will see a scale numbered from 0 to 100.
- 100 means the best health you can imagine.
0 means the worst health you can imagine.

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0

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Resource Use

Resource Use Questions

Have you been discharged from hospital since your brain injury?

- Yes
- No

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)?

a. Hospital inpatient stay

No

Yes - please write the total number of days spent

b. Hospital outpatient clinic

No

Yes - please write the total number of visits

c. Hospital accident and emergency department

No

Yes - please write the total number of visits

d. Other (please specify)

Please write the total number of visits/days spent for this service

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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)?

a. Community ward

No

Yes

a. Community ward

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)?

NHS

Private

In the last three months, have you needed residential nursing care (e.g. step-down facilities, community ward, nursing home)?

b. Rehabilitation unit

No

Yes

b. Rehabilitation unit

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)?

NHS

Private

In the last three months, have you needed residential nursing care (e.g. step-down facilities, community ward, nursing home)?

c. Nursing home/care home

No

Yes

c. Nursing home/care home

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)?

NHS

Private

In the last three months, have you needed residential nursing care (e.g. step-down facilities, community ward, nursing home)?

d. Other (please specify)

d. Other

How many days did you spend receiving such care?

Was this NHS funded or privately funded (either out-of-pocket or through private insurance)?

NHS

Private

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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)?

a. GP, surgery visit

No

Yes - please write the total number of visits/contacts

b. GP, home visit

No

Yes - please write the total number of visits/contacts

c. GP, telephone contact

No

Yes - please write the total number of visits/contacts

d. GP, practice nurse

No

Yes - please write the total number of visits/contacts

e. District nurse, health visitor or member of the community health team

No

Yes - please write the total number of visits/contacts

f. Community physiotherapist

No

Yes - please write the total number of visits/contacts

g. Call to NHS Direct

No

Yes - please write the total number of visits/contacts

h. Call for an ambulance or paramedic

No

Yes - please write the total number of visits/contacts

i. Occupational therapist

No

Yes - please write the total number of visits/contacts

j. Social worker

No

Yes - please write the total number of visits/contacts

k. Counsellor

No

Yes - please write the total number of visits/contacts

l. Home help or care worker

No

Yes - please write the total number of visits/contacts

m. Day centre

No

Yes - please write the total number of visits/contacts

n. Lunch or social club (organised by health or social care providers)

No

Yes - please write the total number of visits/contacts

o. Food, medicine or laundry delivery service (organised by health or social care providers)

No

Yes - please write the total number of visits/contacts

p. Family or patient support or self help groups

No

Yes - please write the total number of visits/contacts

q. Other (please specify, for example have you had any telephone consultations with your GP):

If other, please write the total number of visits/contacts

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

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')
1.	<input type="text"/>	<input type="text"/>	<input type="text"/>
2.	<input type="text"/>	<input type="text"/>	<input type="text"/>
3.	<input type="text"/>	<input type="text"/>	<input type="text"/>
4.	<input type="text"/>	<input type="text"/>	<input type="text"/>
5.	<input type="text"/>	<input type="text"/>	<input type="text"/>
6.	<input type="text"/>	<input type="text"/>	<input type="text"/>

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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?**

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