What is the clinical effect and cost effectiveness of treating upper limb spasticity due to stroke with botulinum toxin?

Study/EudraCT Number: 2004-002427-40
CTA Number: 01511/0266/001-0001

ONE MONTH ASSESSMENT QUESTIONNAIRE

Version 4: 20 July 2006

Patient Initials: _____

Patient Number: _____

Thank you for completing this questionnaire.

Please can you bring it with you when you come to your one month appointment

Study 2004-002427-40	Patient Number ☐☐☐☐		Patient Initials ☐☐☐	***One Month Questionnaire***

How to answer the questions

Thank you for filling in this questionnaire. It may help to complete the questionnaire in several stages. All of your answers will be treated as confidential. Please try to answer every question even if you do not think it applies to you, or if it seems repetitive.

There are several types of questions in this booklet. Most of them can be answered by ticking a box ✓ for either YES or NO.

For example:

Do you live in North Tyneside?

YES ☑

NO ☐

Some of these questions have several boxes and you may be asked to tick one only, or tick as many boxes as apply to you.

For example:

Which vegetables do you like?
(please tick all boxes that apply)

Carrots ☐

Spinach ☑

Brussel sprouts ☐

Cabbage ☑

A small number of questions ask you to write in your answer on a line.

For example:

In what area of North Tyneside do you live?

I live in Whitley Bay

If you need help with the questions, please ask a friend or relative to assist you.

If you are unsure how to answer any of the questions, please contact us on the telephone number below.

If you find a question too difficult to answer or if you do not wish to answer it, please move on to the next question.

If you have any queries or concerns, please contact:

Joseph Hoben
Project Secretary
School of Population & Health Sciences
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The Medical School
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Tel: 0191 222 6779

Study 2004-002427-40	Patient Number ☐☐☐☐		Patient Initials ☐☐☐	***One Month Questionnaire***

PART FIVE – Health & Social Services

The questions in this section ask about the services you may have received within the last ONE month. All of the questions may not apply to you but please try to answer every question.

1. Rehabilitation

Within the last ONE month, have you seen any of the following people?

Person	No	Yes As an inpatient	Yes As an outpatient
a. Physiotherapist – Research study			
b. Physiotherapist - Other			
c. Occupational Therapist			
d. Speech and Language Therapist			
e. Dietician			
f. Chiropodist			
g. Social worker			
h. Clinical psychologist			
i. Other (eg. Doctor or Consultant)			

2. Have you received treatment from any of the services listed below in the table below within the last ONE month?

No ☐ Yes ☐

If Yes, how many times in the last ONE month?

Service	Yes	How many times in the last ONE month?
a. Stroke discharge team/community stroke team		
b. Community rehabilitation team		
c. Day hospital		

3. Have you received any of the following services listed below within the last ONE month?

No ☐ Yes ☐

If Yes, how many times in the last ONE month?

Service	Yes	How many times in the last ONE month?
a. Home care		
b. Private home help		
c. Day centre		
d. Meals on Wheels		
e. Laundry service		
f. Respite care		
g. Other		

4. Have you seen any of the following people listed below within the last ONE month?

No ☐ Yes ☐

If Yes, how many times in the last ONE month?

Person	YES	How many times in the last ONE month?
a. General practitioner		
b. Practice nurse		
c. District nurse		
d. Health visitor		
e. Physiotherapist – Research study		
f. Physiotherapist - Other		
g. Occupational therapist		
h. Speech and language therapist		
i. Dietician		
j. Chiropodist		
k. Social worker		
l. Clinical psychologist		
m. Bath attendant		
n. Continence adviser		
o. Other		

5. Have you been to outpatients other than to attend the upper limb therapy programme in the last ONE month?

No ☐ Yes ☐

If YES, please can you write down the name of the hospital where you attended outpatients and if possible the name of the department or consultant.

Outpatient appointment 1

Name of hospital .....

Name of department or consultant .....

Reason for appointment……

Outpatient appointment 2

Name of hospital .....

Name of department or consultant .....

Reason for appointment ……..

6. Have you been admitted to and/or discharged from hospital within the last ONE month?

No ☐ Yes ☐

If YES, please can you give date of admission and date of discharge

Date of admission……

Reason for admission ……

Name of hospital ……...

Name of department or consultant …….

Date of discharge ……....

Study 2004-002427-40	Patient Number ☐☐☐☐		Patient Initials ☐☐☐	***One Month Questionnaire***

PART SIX - Aids and Adaptations

The questions in this section ask about your home and any aids and adaptations you may have. ***If you currently are living in a residential or nursing home, please omit this section. Thank you for completing this questionnaire.***

1. Do you have any aids, or have any alterations been made in the bathroom to make things easier? (For example, rails or a bath board?)

   No ☐ Yes (or waiting for) ☐

If YES, did you have the alteration/aid to help with bathing before your stroke, after your stroke, or are you waiting for the alteration/aid?

Alteration/aid	Provided before stroke	Provided after stroke	Waiting for
a. Bath or grab rails			
b. Shower			
c. Bath hoist			
d. Bath seat/board			
e. Other - specify			

2. Do you have any aids to help with toileting? (For example, a commode, a raised toilet seat or incontinence aids?)

No ☐ Yes (or waiting for) ☐

If YES**,** did you have the aid to help with toileting before your stroke, after your stroke, or are you waiting for the alteration/aid?

Alteration/aid	**Provided before stroke**	**Provided after stroke**	**Waiting for**
a. Grab rails			
b. Commode			
c. Bedpan/urinal/bottle			
d. Catheter			
e. Raised toilet seat			
f. Incontinence pads			
e. Other - specify			

3. Do you have any aids in the bedroom to make things easier for you to get in and out of bed? (For example, a bed hoist, a bed raise or a special bed?)

No ☐ Yes (or waiting for) ☐

If YES**,** did you have the aid in the bedroom, before your stroke, after your stroke or are you waiting for the alteration/aid?

Aid	**Provided before stroke**	**Provided after stroke**	**Waiting for**
a. Bed hoist			
b. Bed raise/Bed blocks			
c. Special bed/mattress			
d. Other - specify			

4. Do you have any of the following aids for your chair or your bed? (For example, special cushions to prevent pressure sores?)

No ☐ Yes (or waiting for) ☐

If YES, did you have the aid before your stroke, after your stroke or are you waiting for the item?

Aid	Provided before stroke	Provided after stroke	Waiting for
a. Sheepskin			
b. Special cushions			
c. Special chair/Chair raise			
d. Other - specify			

5. Have any alterations been made to the house to make things easier for you to get around?

No ☐ Yes (or waiting for) ☐

If YES, did you have the alteration made before your stroke, after your stroke or are you waiting for the alteration?

Alteration	Provided before stroke	Provided after stroke	Waiting for
a. Widened doorways			
b. Stair rails			
c. Stair lift/Vertical lift			
d. Ramp at front or rear			
e. Other - specify			

6. Do you use any aids for getting about? (For example, a wheelchair or sticks?)

No ☐ Yes (or waiting for) ☐

If YES, did you have the aid before your stroke, after your stroke or are you waiting for the item?

Aid	Provided before stroke	Provided after stroke	Waiting for
a. Manual wheelchair			
b. Electric wheelchair			
c. Walking frame (Zimmer)			
d. Walking stick(s)			
e. Walking trolley			
f. Crutches			
e. Other - specify			

7. Do you have any aids for helping you with meals? (For example, kitchen gadgets or special cutlery?)

No ☐ Yes (or waiting for) ☐

If YES, did you have the aid before your stroke, after your stroke or are you waiting for the item?

Aid	Provided before stroke	Provided after stroke	Waiting for
a. Kitchen gadgets			
b. Special cutlery/crockery			
c. Feeding tubes			
d. Other - specify			

Thank you for completing this questionnaire. Please see front page for returning instructions.