Participant study/record number:	
Diagnosis summary:	□Cancer □Non-Cancer
No. of weeks individual has been	
on the palliative care register or	
service caseload:	

**Medicine Prescriptions** 

- Please give details of ALL medicines used or prescribed over the data collection period

**Frequency of dose code:** 1=od, 2=bd, 3=tds, 4=qds, 5=prn

Who prescribed it code: 1=GP own, 2=GP out of hours, 3=Palliative care consultant, 4=Specialist nurse, 5=District nurse, 6=Pharmacist, 7=Not known, 8=Other (please state)

Please add further rows if required

## **Hospital** Attendance

Date of prescription day/month/yr	Name of medication	Dose and units	Frequency of dose please use code above	Quantity	New or repeat prescription delete as appropriate	Who prescribed it please use code above	Date prescription dispensed day/month/yr	Electronic (EPS) or paper prescription delete as appropriate
	1.				New/repeat			EPS/paper
	2.				New/repeat	1		EPS/paper
	3.				New/repeat	1		EPS/paper
	4.				New/repeat			EPS/paper
	5.				New/repeat	1		EPS/paper
	6.				New/repeat			EPS/paper
	7.				New/repeat			EPS/paper
	8.				New/repeat			EPS/paper
	9.				New/repeat			EPS/paper
	10.				New/repeat	1		EPS/paper
	11.				New/repeat	1		EPS/paper
	12.				New/repeat	1		EPS/paper
	13.				New/repeat			EPS/paper
	14.				New/repeat			EPS/paper
	15.				New/repeat			EPS/paper
	16.				New/repeat			EPS/paper
	17.				New/repeat	1		EPS/paper
	18.				New/repeat	1		EPS/paper
	19.				New/repeat	1		EPS/paper
	20.				New/repeat	1		EPS/paper
	21.	1			New/repeat			EPS/paper
	22.	1			New/repeat			EPS/paper
	23.				New/repeat			EPS/paper
	24.				New/repeat			EPS/paper
	25.				New/repeat			EPS/paper
	26.	1			New/repeat			EPS/paper
	27.	1			New/repeat			EPS/paper
	28.				New/repeat			EPS/paper
	29.				New/repeat			EPS/paper
	30.	1			New/repeat			EPS/paper

## *Has the individual attended hospital over the data collection period?* □Yes □No *If yes,* please give details:

Day	Hospital attendance	□Planned □Unplanned					
Duy	riospital attendance	$\Box$ In hours $\Box$ Out of hours					
	Туре						
	Type	Outpatient DA&E DInpatient, if yes was there HDU/ICU involvement?					
Add		$\Box$ Yes $\Box$ No $\Box$ Not known					
no.	Reason	Other, please state:					
	(tick all that apply)	□Symptom management □Disease treatment and follow up					
	Overall length of stay	□Other, specify:   Total no. of days:					
	if admitted						
Day	Hospital attendance	□Planned □Unplanned					
		□In hours □Out of hours					
	Туре	□Outpatient □A&E □Inpatient, if yes was there HDU/ICU involvement?					
Add		$\Box$ Yes $\Box$ No $\Box$ Not known					
no.		□Other, please state:					
	Reason	□Symptom management □Disease treatment and follow up					
	(tick all that apply)	□Other, specify:					
	Overall length of stay if admitted	Total no. of days:					
Day	Hospital attendance	□Planned □Unplanned					
		□In hours □Out of hours					
	Туре	□Outpatient □A&E □Inpatient, if yes was there HDU/ICU involvement?					
Add		$\Box$ Yes $\Box$ No $\Box$ Not known					
no.		□Other, please state:					
	Reason	□Symptom management □Disease treatment and follow up					
	(tick all that apply)	□Other, specify:					
	Overall length of stay	Total no. of days:					
D	if admitted						
Day	Hospital attendance						
		□In hours □Out of hours					
	Туре	□Outpatient □A&E □Inpatient, if yes was there HDU/ICU involvement?					
Add		$\Box$ Yes $\Box$ No $\Box$ Not known					
no.	Daaraa	Other, please state:					
	Reason (tick all that apply)	□Symptom management □Disease treatment and follow up					
	Overall length of stay	Dother, specify: Total no. of days:					
	if admitted	Total no. of days:					
Day	Hospital attendance	□Planned □Unplanned					
		□In hours □Out of hours					
	Туре	□Outpatient □A&E □Inpatient, if yes was there HDU/ICU involvement?					
Add		🗆 Yes 🗆 No 🗆 Not known					
no.		□Other, please state:					
	Reason	□Symptom management □Disease treatment and follow up					
	(tick all that apply)	□Other, specify:					
	Overall length of stay if admitted	Total no. of days:					
Diago	add further rows if red						

Please add further rows if required

## **Hospice** Attendance

*Has the individual attended hospice over the data collection period?* □Yes □No □Not known (no access to palliative care records) *If yes,* please give details:

Day	Hospice attendance	□Planned □Unplanned
		□In hours □Out of hours
	Туре	□Inpatient □Outpatient appointment □Day hospice visit
Add no.	Reason (tick all that apply)	□Symptom management □Other, specify:
no.	Overall length of stay if admitted	Total no. of days:
Day	Hospice attendance	□Planned □Unplanned
		□In hours □Out of hours
	Туре	□Inpatient □Outpatient appointment □Day hospice visit
Add	Reason	□Symptom management □Other, specify:
no.	(tick all that apply)	
	Overall length of stay if admitted	Total no. of days:
Day	Hospice attendance	□Planned □Unplanned
		□In hours □Out of hours
	Туре	□Inpatient □Outpatient appointment □Day hospice visit
Add no.	Reason (tick all that apply)	□Symptom management □Other, specify:
no.	Overall length of stay if admitted	Total no. of days:
Day	Hospice attendance	□Planned □Unplanned
		$\Box$ In hours $\Box$ Out of hours
	Туре	□Inpatient □Outpatient appointment □Day hospice visit
Add	Reason (tick all that apply)	□Symptom management □Other, specify:
no.	Overall length of stay if admitted	Total no. of days:
Day	Hospice attendance	□Planned □Unplanned
		□In hours □Out of hours
	Туре	□Inpatient □Outpatient appointment □Day hospice visit
Add no.	Reason (tick all that apply)	□Symptom management □Other, specify:
no.	Overall length of stay if admitted	Total no. of days:
Day	Hospice attendance	□Planned □Unplanned
		□In hours □Out of hours
	Туре	□Inpatient □Outpatient appointment □Day hospice visit
Add	Reason	□Symptom management □Other, specify:
лии 110.	(tick all that apply)	
	Overall length of stay if admitted	Total no. of days:
Day	Hospice attendance	□Planned □Unplanned
		□In hours □Out of hours
	Туре	□Inpatient □Outpatient appointment □Day hospice visit
Add	Reason	□Symptom management □Other, specify:
no.	(tick all that apply)	
	Overall length of stay if admitted	Total no. of days:
Diagaa	add further rows if re	aution d

Please add further rows if required

## What other healthcare services have been used during the data collection period?

Type of service	Has this	s service	been used?	Please list all days when the service was used (add respective no.s)
GP, surgery visit GP, home visit GP, telephone consultation	□Yes □Yes □Yes	□No □No □No		
GP, out of hours, GP base visit GP, out of hours, home visit GP, out of hours, telephone consultation	□Yes □Yes □Yes	□No □No □No	□Not known □Not known □Not known	
Primary care pharmacist (practice based), surgery visit Primary care pharmacist (practice based), home visit Primary care pharmacist (practice based), telephone consultation	□Yes □Yes □Yes	□No □No □No		
Practice nurse or nurse practitioner, surgery visit Practice nurse or nurse practitioner, telephone consultation	□Yes □Yes	□No □No		
District nurse, home visit District nurse, telephone consultation	□Yes known □Yes	□No	□Not □Not known	
Palliative care clinical nurse specialist, home visit Palliative care clinical nurse specialist, telephone consultation	□Yes □Yes	□No □No	□Not known □Not known	
NHS 111, telephone call	□Yes	□No	□Not known	
999 ambulance service, telephone call Paramedic, home visit	□Yes □Yes	□No □No	□Not known □Not known	
Other, please state (professional <u>and</u> visit/consultation type):	□Yes	□No		