Patient Initials		Date of Birth	Day Month Year	Patient ID	Centre No	Trial No

Carer ID:	

Pain Management and Dementia

Carer Health Survey (Staff)

The purpose of this questionnaire is to collect information about the health of the patient you provide care for. When answering on behalf of the patient **please do not ask them for information about the answers**. This is because we want to find out whether formal carers (such as nursing staff) can provide accurate information when patients are unable to.

The information you provide will help us understand the impact of pain on the patient with dementia.

Section 1 is questions about you. Sections 2 and 3 are questions about the patient.

Please answer all of the questions you feel able to. There are no right or wrong answers. All of your responses are anonymous and confidential and **will not** affect any treatment the patient might receive in the future.

Please enter today's date:

d d	m m	y y y y

Section 1: About you

1. What is your job title? (Please write)

_____

2. How well would you say you know the patient (their current condition and clinical history), on a scale of 1-5?

1	2	3	4	5
I don't know them at all		I know them quite well		I know them very well
❑	❑	❑	❑	❑

3. How confident would you be on a scale of 1-5 that when you respond to a health questionnaire on behalf of the patient you accurately reflect their experience?

1	2	3	4	5
Not at all confident		Quite confident		Very confident
❑	❑	❑	❑	❑

The following questions are about the person you care for, the patient.

Section 2: Contact with Health Services

All the questions in Section 2 refer to the **last month**. Questions 1-3 relate to the patient's stay in hospital.

1. Which department(s)/ward(s) have they spent their time over the last month on? Please tick each that applies and provide the number of days they have spent in each.

	General Medicine	**General Surgery**	**Orthopaedic**	**Oncology**	**High Dependency Unit**	**Intensive Care Unit**	**Other** (please specify)
Please tick each that applies							
Number of days							

2. In the **last month** whilst they have been in hospital have they had any assessments?

   please mark a cross in the appropriate box)

   Yes ☐ No ☐

If you have answered **Yes to question 2**, please could you tell us what their assessment was for or who they saw?

Medical assessment (excluding daily ward rounds):	**Please tick each assessment they had**	**Number of times**
Surgical		
Orthopaedic		
Oncology		
Cardiology		
Respiratory		
Radiography		
CT scan		
MRI Scan		
X Ray		
Pathology		
Blood tests		
Other assessments, meetings or sessions		
Physiotherapist		
Occupational therapist		
Psychologist		
Dietician		
Speech and language therapist		
Social worker		
Other:		

3. In the **last month** whilst they have been in hospital have they had an operation or any other procedure? (please mark a cross in the appropriate box)

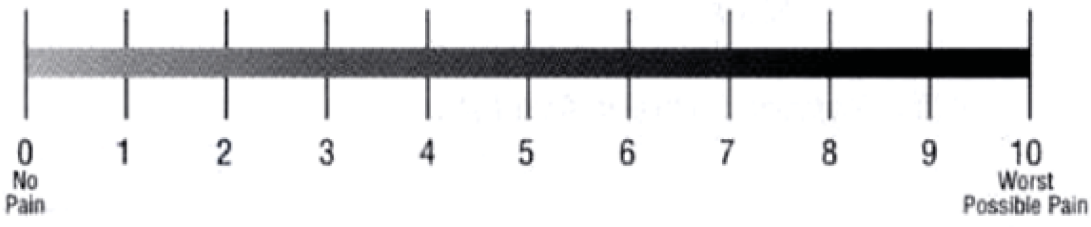
   Yes ☐ No ☐

If you have answered **Yes to question 3**, please could you tell us what their operation or procedure was for? We have left space for up to four but if there are more please put the details at the end of the form

Details of operation (for example, hip replacement) of procedure (for example, laryngosophy)
I. Details:
II. Details:
III. Details:
IV. Details:

Section 3: Pain Assessments

1. Thinking about the patient, please mark on the rating scale below (with an **X**) what you think their average level of pain over the last 24 hours has been. Please make sure your **X** is visible. Please do not ask the patient about their pain level while completing this.



2. Is the patient currently taking pain medication? (please tick)

   ❑ Yes (please go to Question 3)

   ❑ No (please go to the next section)

3. Again, thinking about the patient, in the last 24 hours, how much relief have pain treatments or medications provided? Please circle the percentage that most shows how much relief you think they have received.

0% **10%** **20%** **30%** **40%** **50%** **60%** **70%** **80%** **90%** **100%**

No Relief — Complete Relief

Section 4: EQ-5D – Proxy & DEMQOL Proxy

Health-Related Quality of Life – The person you provide care for

Thinking about the patient, place a tick in **one** box in each group below, indicating which statement best describes **their** health state **today**.

Mobility

- They have no problems in walking about ❑
- They have some problems walking about ❑
- They are confined to bed ❑

Self Care

- They have no problems with self care ❑
- They have some problems washing or dressing himself/herself ❑
- They are unable to wash or dress himself/herself ❑

Usual Activities

(e.g. work, study, housework, family or leisure activities)

- They have no problems with performing usual activities ❑
- They have some problems with performing usual activities ❑
- They are unable to perform usual activities ❑

Pain/Discomfort

- They have no pain or discomfort ❑
- They have moderate pain or discomfort ❑
- They have extreme pain or discomfort ❑

Anxiety/Depression

- They are not anxious or depressed ❑
- They are moderately anxious or depressed ❑
- They are extremely anxious or depressed ❑

We would like to know how good or bad **the patient's** health is TODAY

The best health you can imagine

The worst health you can imagine

This 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 **their** health is TODAY.

Now, please write the number you marked on the scale in the box below:

THEIR HEALTH TODAY: [ ]