GNOME: Costs to parents 1

To be completed when taking BASELINE measures

Study ID number: | | | | | | | |

1. SELF-MEDICATION USE FOR EAR PROBLEMS

Over the **past 12 months** have you self-treated your child (without coming to surgery) for an ear problem?

a) Using decongestant or antihistamine medicines/tablets? ☐ Yes ☐ No

If YES, how many occasions? ☐ 0–1 ☐ 1–2 ☐ 2–4 ☐ More than 4

b) Using a nose spray? ☐ Yes ☐ No

If YES, how many occasions? ☐ 0–1 ☐ 1–2 ☐ 2–4 ☐ More than 4

c) Using pain relieving medicine such as paracetamol, calpol, junior ibuprofen? ☐ Yes ☐ No

If YES, how many occasions? ☐ 0–1 ☐ 1–2 ☐ 2–4 ☐ More than 4

2. CONTACT WITH HEALTHCARE PROVIDERS

a) Has your child been admitted to hospital in the past 12 months?

Yes ☐ No ☐

If yes,

Name of hospital	Name of ward	Reason for admission	Date of admission	Date of discharge

b) Has your child had any operations over the past 12 months? ☐ Yes ☐ No

If yes,

Name of hospital	Type of operation

c) Has your child used any of the following hospital outpatient services over the past 12 months?

a) A&E Yes ☐ No ☐ If yes, total number of attendances ……..….

b) Audiology dept Yes ☐ No ☐ If yes, total number of attendances ……..….

c) ENT Yes ☐ No ☐ If yes, total number of attendances …….

d) Other, please specify …… If yes, total number of attendances …….

d) Has your child seen any of the following community healthcare professionals over the past 12 months?

Community healthcare professional	*Please tick one box*	Total number of occasions (if applicable)
GP	Yes ☐ No ☐	
Practice nurse	Yes ☐ No ☐	
District nurse	Yes ☐ No ☐	
Health visitor	Yes ☐ No ☐	
Speech therapist	Yes ☐ No ☐	
Hearing therapist	Yes ☐ No ☐	
Other (please specify) ……..	Yes ☐ No ☐	

3. YOUR DETAILS

a) What is the highest grade of school you have completed?

	You	Partner
School to 16, no qualifications	☐	☐
School to 16, GCSEs/O levels	☐	☐
Sixth form school or college, A levels, ND	☐	☐
Highers, Scotvec or NVQ	☐	☐
University degree	☐	☐
Professional or postgraduate degree	☐	☐

b) Which of the following best describes your current marital status?

Married or living with partner	Single	Separated or divorced	Widowed
☐	☐	☐	☐

c) Which of the following best describes YOUR CHILD'S racial background?

☐ White ☐ Oriental ☐ Afro-Caribbean

☐ Bangladeshi/Indian ☐ Mixed race ☐ Other group

If mixed race or other group, please specify ……

d) Is English the first language spoken at home?

Yes ☐ No ☐

If NO, which language is used?.....

e) What is your annual gross family income (before any tax deductions and including Benefits)?

☐ Less than £10k ☐ £10k–£20k ☐ £21k–£30k

☐ £31k–£40k ☐ £41k–£50k ☐ Over £50k

GNOME: Costs to parents 2

To be completed when taking 3 MONTH measures

Study ID number: | | | | | | | |

1. SELF-MEDICATION USE FOR EAR PROBLEMS

Over the **past 3 months** have you self-treated your child (without coming to surgery) for an ear problem?

a) Using decongestant or antihistamine medicines/tablets? ☐ Yes ☐ No

If YES, how many occasions? ☐ 0–1 ☐ 1–2 ☐ 2–4 ☐ More than 4

b) Using a nose spray? ☐ Yes ☐ No

If YES, how many occasions? ☐ 0–1 ☐ 1–2 ☐ 2–4 ☐ More than 4

c) Using pain relieving medicine such as paracetamol, calpol, junior ibuprofen? ☐ Yes ☐ No

If YES, how many occasions? ☐ 0–1 ☐ 1–2 ☐ 2–4 ☐ More than 4

2. CONTACT WITH HEALTHCARE PROVIDERS

a) Has your child been admitted to hospital in the past 3 months?

Yes ☐ No ☐

If yes,

Name of hospital	Name of ward	Reason for admission	Date of admission	Date of discharge

b) Has your child had any operations over the past 3 months? ☐ Yes ☐ No

If yes,

Name of hospital	Type of operation

c) Has your child used any of the following hospital outpatient services over the past 3 months?

a) A&E Yes ☐ No ☐ If yes, total number of attendances ……..….

b) Audiology dept Yes ☐ No ☐ If yes, total number of attendances ……..….

c) ENT Yes ☐ No ☐ If yes, total number of attendances …….

d) Other, please specify …… If yes, total number of attendances …….

d) Has your child seen any of the following community healthcare professionals over the past 3 months?

Community healthcare professional	*Please tick one box*	Total number of occasions (if applicable)
GP	Yes ☐ No ☐	
Practice nurse	Yes ☐ No ☐	
District nurse	Yes ☐ No ☐	
Health visitor	Yes ☐ No ☐	
Speech therapist	Yes ☐ No ☐	
Hearing therapist	Yes ☐ No ☐	
Other (please specify) ……..	Yes ☐ No ☐	

GNOME: Costs to parents 3

To be completed when taking 9 MONTH measures

Study ID number: | | | | | | | |

1. SELF-MEDICATION USE FOR EAR PROBLEMS

Over the **past 6 months** have you self-treated your child (without coming to surgery) for an ear problem?

a) Using decongestant or antihistamine medicines/tablets? ☐ Yes ☐ No

If YES, How many occasions? ☐ 0–1 ☐ 1–2 ☐ 2–4 ☐ More than 4

b) Using a nose spray? ☐ Yes ☐ No

If YES, How many occasions? ☐ 0–1 ☐ 1–2 ☐ 2–4 ☐ More than 4

c) Using pain relieving medicine such as paracetamol, calpol, junior ibuprofen? ☐ Yes ☐ No

If YES, How many occasions? ☐ 0–1 ☐ 1–2 ☐ 2–4 ☐ More than 4

2. CONTACT WITH HEALTHCARE PROVIDERS

a) Has your child been admitted to hospital in the past 6 months?

Yes ☐ No ☐

If yes,

Name of hospital	Name of ward	Reason for admission	Date of admission	Date of discharge

b) Has your child had any operations over the past 6 months? ☐ Yes ☐ No

If yes,

Name of hospital	Type of operation

c) Has your child used any of the following hospital outpatient services over the past 6 months?

a) A&E Yes ☐ No ☐ If yes, total number of attendances ……..….

b) Audiology dept Yes ☐ No ☐ If yes, total number of attendances ……..….

c) ENT Yes ☐ No ☐ If yes, total number of attendances …….

d) Other, please specify …… If yes, total number of attendances ……..….

d) Has your child seen any of the following community healthcare professionals over the past 6 months?

Community healthcare professional	*Please tick one box*	Total number of occasions (if applicable)
GP	Yes ☐ No ☐	
Practice nurse	Yes ☐ No ☐	
District nurse	Yes ☐ No ☐	
Health visitor	Yes ☐ No ☐	
Speech therapist	Yes ☐ No ☐	
Hearing therapist	Yes ☐ No ☐	
Other (please specify) ……..	Yes ☐ No ☐	

GNOME: Health Economic Evaluation Form 1

To be completed at time of taking BASELINE MEASURES by computer search

Study ID number: | | | | | | | |

In the previous 12 months

1. All appointments

	Ear related	**Non-ear related**
List the dates of surgery appointments with GP		
List the dates of surgery appointments with practice nurse		
List the dates of surgery appointments with health visitor		
List the dates of home visits by GP		
List the dates of home visits by district nurse		
List the dates of home visits by health visitor		
List the dates of telephone consultations with GP		
List the dates of telephone consultations with practice nurse		
List the dates of out of hours consultations with GP		

2. Treatment courses for OM or OME (ear problems)

a) Antibiotics:

Date …….. name …….. dose …….. days ……
Date …….. name …….. dose …….. days ……
Date …….. name …….. dose …….. days ……
Date …….. name …….. dose …….. days ……
Date …….. name …….. dose …….. days ……
Date …….. name …….. dose …….. days ……

b) Autoinflation Yes / No

if yes, date …… no. of times per day …… total duration of treatment ……

c) Decongestants and antihistamines:

Date …….. name …….. dose …….. days ……
Date …….. name …….. dose …….. days ……
Date …….. name …….. dose …….. days ……

d) Analgesics:

Date …….. name …….. dose …….. days ……
Date …….. name …….. dose …….. days ……

Prescribed medication for other reasons

Date …….. name …….. dose …….. days ……
Date …….. name …….. dose …….. days ……
Date …….. name …….. dose …….. days ……
Date …….. name …….. dose …….. days ……

3. Any investigations in their records

e.g. blood tests / X-rays,

Please state what …… Date: …… Number ……
Please state what …… Date: …… Number ……
Please state what …… Date: …… Number ……

4. Outpatient hospital referrals

Date ……
Main reason ……
……
To where?
☐ ENT ☐ Audiology
☐ Other please state ……..

Date ……
Main reason ……
……
To where?
☐ ENT ☐ Audiology
☐ Other please state ……....

Date ……

Main reason ……

……

To where?

☐ ENT ☐ Audiology

☐ Other please state ……..

Date ……

Main reason ……

……

To where?

☐ ENT ☐ Audiology

☐ Other please state ……

5. Referral for speech therapy

Date ……

main reason ……

……..

to where? ……

Date ……

main reason ……

……..

to where? ……

6. Referral to community healthcare professional (e.g. community paediatrician)

Date ……

Main reason ……

……..

To where? ……

Date ……

Main reason ……

……..

To where? ……

Date ……

Main reason ……

……..

To where? ……

Date ……

Main reason ……

……..

To where? ……

7. Hospitalisation

Was the child admitted to hospital for:

a) Grommets / t-tubes / ventilation tubes: Yes / No

b) Adenoidectomy: planned Yes / No

done Yes / No

c) Other reason Yes / No

If yes, please state ……

If yes to a) or b) or c) please state:

Name of hospital	Name of ward	Date of admission	Date of discharge
……	……..	……..	……..……
……	……..	……..	……..……
……	……..	……..	……..……

GNOME: Health Economic Evaluation Form 2

To be completed at time of taking 9 MONTH MEASURES by computer search

Study ID number: | | | | | | | |

In the previous 9 months

1. All appointments

	Ear related	**Non-ear related**
List the dates of surgery appointments with GP		
List the dates of surgery appointments with practice nurse		
List the dates of surgery appointments with health visitor		
List the dates of home visits by GP		
List the dates of home visits by district nurse		
List the dates of home visits by health visitor		
List the dates of telephone consultations with GP		
List the dates of telephone consultations with practice nurse		
List the dates of out of hours consultations with GP		

2. Treatment courses for OM or OME (ear problems)

a) Antibiotics:

Date …….. name …….. dose …….. days ……
Date …….. name …….. dose …….. days ……
Date …….. name …….. dose …….. days ……
Date …….. name …….. dose …….. days ……
Date …….. name …….. dose …….. days ……
Date …….. name …….. dose …….. days ……

b) Autoinflation Yes / No

If yes, date …… no. of times per day ……. total duration of treatment ……

c) Decongestants and antihistamines:

Date …….. name …….. dose …….. days ……
Date …….. name …….. dose …….. days ……
Date …….. name …….. dose …….. days ……

d) Analgesics:

Date …….. name …….. dose …….. days ……
Date …….. name …….. dose …….. days ……

Prescribed medication for other reasons

Date …….. name …….. dose …….. days ……
Date …….. name …….. dose …….. days ……
Date …….. name …….. dose …….. days ……
Date …….. name …….. dose …….. days ……

3. Any Investigations in their records

e.g. blood tests / X-rays,

Please state what …… Date: …… Number ……
Please state what …… Date: …… Number ……
Please state what …… Date: …… Number ……

4. Outpatient hospital referrals

Date ……
Main reason ……
……
To where?

☐ ENT ☐ Audiology
☐ Other please state ……..

Date ……
Main reason ……
……
To where?

☐ ENT ☐ Audiology
☐ Other please state ……..

Date ……

Main reason ……

……

To where?

☐ ENT ☐ Audiology

☐ Other please state ……...

Date ……

Main reason ……

……

To where?

☐ ENT ☐ Audiology

☐ Other please state ……...

5. Referral for speech therapy

Date ……

Main reason ……

……..

To where? ……

Date ……

Main reason ……

……..

To where? ……

6. Referral to community healthcare professional (e.g. community paediatrician)

Date ……

Main reason ……

……..

To where? ……

Date ……

Main reason ……

……..

To where? ……

Date ……

Main reason ……

……..

To where? ……

Date ……

Main reason ……

……..

To where? ……

7. Hospitalisation

Was the child admitted to hospital for:

a) Grommets / t-tubes / ventilation tubes: Yes / No

b) Adenoidectomy: planned Yes / No

done Yes / No

c) Other reason Yes / No

If yes, please state ……

If Yes to a) or b) or c) please state:

Name of hospital	Name of ward	Date of admission	Date of discharge
……	……..	……..	……..……
……	……..	……..	……..……
……	……..	……..	……..……

GNOME study

Your health today

Study ID number: | | | | | | | |

Version 2, dated 18/4/05

Parents / guardians

Please can you complete this questionnaire for your child. Where possible please ask your child the questions and get their response. We realise that for very young children this may be difficult but please do the best you can.

Section 1: Describing your child's health TODAY

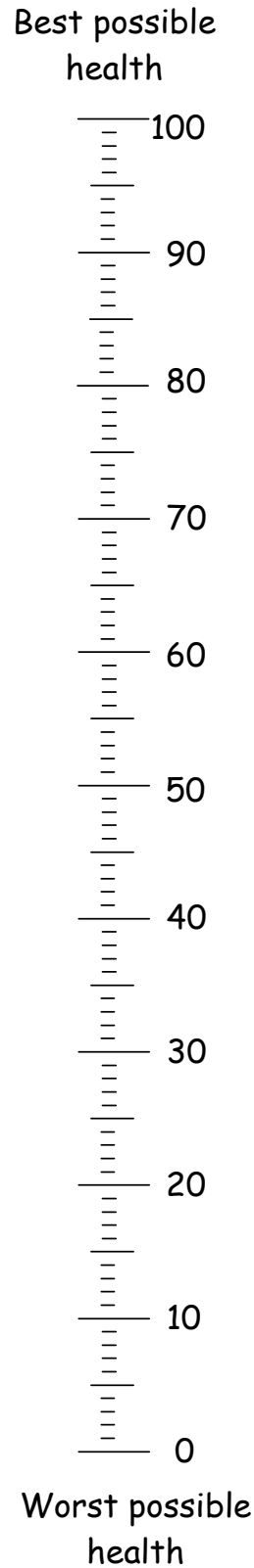
Please tick ONE box in each section which best describes your child's health TODAY

Mobility	
Your child has no problems walking about	❑ 1
	❑ 2
Your child has some problems walking about	❑ 3
	❑ 4
Your child had a lot of problems walking about	❑ 5
Self-care	
Your child has no problems washing or dressing himself/herself	❑ 1
	❑ 2
Your child has some problems washing or dressing himself/herself	❑ 3
	❑ 4
Your child is unable to wash or dress himself/herself	❑ 5
Usual activities (e.g. going to school, hobbies, sports, playing)	
Your child has no problems with performing his/her usual activities	❑ 1
	❑ 2
Your child has some problems with performing his/her usual activities	❑ 3
	❑ 4
Your child is unable to perform his/her usual activities	❑ 5
Pain / discomfort	
Your child has no pain or discomfort	❑ 1
	❑ 2
Your child has moderate pain or discomfort	❑ 3
	❑ 4
Your child has extreme pain or discomfort	❑ 5
Feeling worried, sad or unhappy	
Your child is not worried, sad or unhappy	❑ 1
	❑ 2
Your child is moderately worried, sad or unhappy	❑ 3
	❑ 4
Your child is extremely worried, sad or unhappy	❑ 5

Section 2: How good is your child's health TODAY

- Please indicate on this scale how good or bad your child's health is today.
- The best possible health you can imagine is marked 100.
- The worst possible health you can imagine is marked 0.
- Please draw a line from the box below to the point on the scale that indicates how good or bad your child's health is today.

Your child's health today



Section 3: About your child's health in general

Please tick **ONE** box for each question

1. During the last 12 months how has your child's health been in general? Would you say it has been:

Very good ❑ Good ❑ Fair ❑ Poor ❑ Very poor ❑

2. During the last 2 weeks has your child had to cut down on any of the things they usually do (for example at school) because of illness or injury?

Yes ❑ No ❑

3. During the last month has your child had any health problems that they needed to see their doctor or practice nurse about?

Yes ❑ No ❑

4. Does your child have any of these conditions?

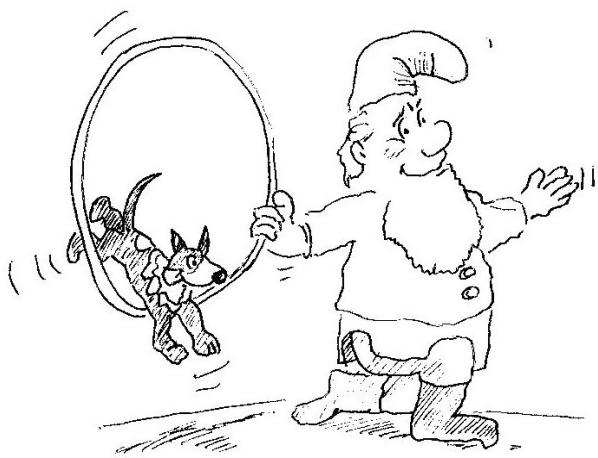
Asthma	Yes ❑	No ❑
Eczema	Yes ❑	No ❑
Hay fever	Yes ❑	No ❑
Diabetes	Yes ❑	No ❑

Thank you for helping us

HUI23P4E.15Q

Health Utilities Index Mark 2 and Mark 3 (HUI2/3)
15-item questionnaire for self-administered, proxy-assessed
'Four week' Health Status Assessment

GNOME Study



Study ID number: | | | | | | | |

Date questionnaire completed ……

Version 1, dated 18 May 2005

Health Utilities Inc. (HUInc)
88 Sydenham Street
Dundas ON, Canada L9H 2V3
Tel (905) 525-9140, ext 22389 / 22377
Fax (905) 627-7914
http://www.healthutilities.com

1. Which **ONE** of the following best describes your child's ability, during the past 4 weeks, to see well enough to read ordinary newsprint?
   a. Able to see well enough without glasses or contact lenses
   b. Able to see well enough with glasses or contact lenses
   c. Unable to see well enough even with glasses or contact lenses
   d. Unable to see at all

2. Which **ONE** of the following best describes your child's ability, during the past 4 weeks, to see well enough to recognise a friend on the other side of the street?
   a. Able to see well enough without glasses or contact lenses
   b. Able to see well enough with glasses or contact lenses
   c. Unable to see well enough even with glasses or contact lenses
   d. Unable to see at all

3. Which **ONE** of the following best describes your child's ability, during the past 4 weeks, to hear what was said **in a group conversation with at least three other people**?
   a. Able to hear what is said without a hearing aid
   b Able to hear what is said with a hearing aid
   c. Unable to hear what is said even with a hearing aid
   d. Unable to hear what is said, but does not wear a hearing aid
   e. Unable to hear at all

4. Which **ONE** of the following best describes your child's ability, during the past 4 weeks, to hear what was said **in a conversation with one other person in a quiet room**?
   a. Able to hear what is said without a hearing aid
   b Able to hear what is said with a hearing aid
   c. Unable to hear what is said even with a hearing aid
   d. Unable to hear what is said, but does not wear a hearing aid
   e. Unable to hear at all

5. Which **ONE** of the following best describes your child's ability, during the past 4 weeks, to be understood when speaking his/her own language with people who do not know them?
   a. Able to be understood completely
   b. Able to be understood partially
   c. Unable to be understood
   d. Unable to speak at all

6. Which **ONE** of the following best describes your child's ability, during the past 4 weeks, to be understood when speaking with people who know them well?

   a. Able to be understood completely
   b. Able to be understood partially
   c. Unable to be understood
   d. Unable to speak at all

7. Which **ONE** of the following best describes your child's feelings during the past 4 weeks?

   a. Happy and interested in life
   b. Somewhat happy
   c. Somewhat unhappy
   d. Very unhappy
   e. So unhappy that life is not worthwhile

8. Which **ONE** of the following best describes the pain and discomfort your child has experienced during the past 4 weeks?

   a. Free of pain and discomfort
   b. Mild to moderate pain or discomfort that prevents no activities
   c. Moderate pain or discomfort that prevents a few activities
   d. Moderate to severe pain or discomfort that prevents some activities
   e. Severe pain or discomfort that prevents most activities

9. Which **ONE** of the following best describes your child's ability, during the past 4 weeks, to walk? Note: Walking equipment refers to mechanical supports such as braces, a cane, crutches or a walker.

   a. Able to walk around the neighbourhood without difficulty, and without walking equipment
   b. Able to walk around the neighbourhood with difficulty, but does not require walking equipment or the help of another person
   c. Able to walk around the neighbourhood with walking equipment, but without the help of another person
   d. Able to walk only short distances with walking equipment, and requires a wheelchair to get around the neighbourhood
   e. Unable to walk alone, even with walking equipment. Able to walk short distances with the help of another person, and requires a wheelchair to get around the neighbourhood
   f. Unable to walk at all

10. Which **ONE** of the following best describes your child's ability, during the past 4 weeks, to use his/her hands and fingers? Note: Special tools refers to hooks for buttoning clothes, gripping devices for opening jars or lifting small items, and other devices to compensate for limitations of hands and fingers.

    a. Full use of two hands and ten fingers
    b. Limitations in the use of hands or fingers, but does not require special tools or the help of another person
    c. Limitations in the use of hands or fingers, independent with use of special tools (does not require the help of another person)
    d. Limitations in the use of hands or fingers, requires the help of another person for some tasks (not independent even with use of special tools)
    e. Limitations in the use of hands or fingers, requires the help of another person for most tasks (not independent even with use of special tools)
    f. Limitations in the use of hands or fingers, requires the help of another person for all tasks (not independent even with use of special tools)

11. Which **ONE** of the following best describes your child's ability, during the past 4 weeks, to remember things?

a. Able to remember most things

b. Somewhat forgetful

c. Very forgetful

d. Unable to remember anything at all

12. Which **ONE** of the following best describes your child's ability, during the past 4 weeks, to think and solve day to day problems?

a. Able to think clearly and solve day to day problems

b. Has a little difficulty when trying to think and solve day to day problems

c. Has some difficulty when trying to think and solve day to day problems

d. Has great difficulty when trying to think and solve day to day problems

e. Unable to think or solve day to day problems

13. Which **ONE** of the following best describes your child's ability, during the past 4 weeks, to perform basic activities?

a. Eats, bathes, dresses and uses the toilet normally

b. Eats, bathes, dresses and uses the toilet independently with difficulty

c. Requires mechanical equipment to eat, bathe, dress or use the toilet independently

d. Requires the help of another person to eat, bathe, dress or use the toilet

14. Which **ONE** of the following best describes your child's feelings during the past 4 weeks?

a. Generally happy and free from worry

b. Occasionally fretful, angry, irritable, anxious or depressed

c. Often fretful, angry, irritable, anxious or depressed

d. Almost always fretful, angry, irritable, anxious or depressed

e. Extremely fretful, angry, irritable, anxious or depressed; to the point of needing professional help

15. Which **ONE** of the following best describes the pain or discomfort your child has experienced during the past 4 weeks?

a. Free of pain and discomfort

b. Occasional pain or discomfort. Discomfort relieved by non-prescription medication or self-control activity without disruption of normal activities

c. Frequent pain or discomfort. Discomfort relieved by oral medicines with occasional disruption of normal activities

d. Frequent pain or discomfort; frequent disruption of normal activities. Discomfort requires prescription medication for relief

e. Severe pain or discomfort. Pain not relieved by medication and constantly disrupts normal activities

16. Overall how would you rate your child's health during the past 4 weeks?

a. Excellent

b. Very good

c. Good

d. Fair

e. Poor

17. Who provided information used to answer the questions in this questionnaire? (please indicate all that apply)

a. Person recording the answers on the form

b. Child

c. Others. Please list the relationship between your child and each person who provided information:

1. ……

2. ……

3. ……

4. ……

18. Who recorded the answers on this questionnaire form?

a. Parent of the child

b. Other (please specify) ……

Many thanks for all your help