ARCTIC

Patient Health Economics Questionnaire Booklet

For Hospital Use

To be completed 3 months after the end of therapy and 6, 9, 12, 15, 18, 21 and 24 months post-randomisation.

Patient initials

Patient date of birth (Day Month Year)

Hospital name

Today's date (Day Month Year)

Timepoint:

- ☐ 3 months after the end of therapy
- ☐ 6 months post-randomisation
- ☐ 9 months post-randomisation
- ☐ 12 months post-randomisation
- ☐ 15 months post-randomisation
- ☐ 18 months post-randomisation
- ☐ 21 months post-randomisation
- ☐ 24 months post-randomisation

Information

We need to ask you some questions about the health care services you have used and anything you have had to buy because of your diagnosis during the last 3 months. We are doing this to find out the costs of the different approaches to treatment.

Some questions will seem more relevant to you than others, but please try to answer all the questions so that we can compare the costs of the treatments fairly. The responses are confidential and will not be seen by the doctors or nurses.

When you have completed the questionnaire booklet, please place it in the envelope provided and return the sealed envelope to the nurse.

Thank you

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Use of health and social services

1. Please record information on the health and social services that you have used <u>during the last 3 months</u>.

Type of service	Which services have you used since during the last 3 months?	Total number of <u>face to face</u> contacts you have had during the last 3 months	Total number of contacts you had by <u>telephone or e-mail</u> during the last 3 months
GP surgery visit	Yes ☐ No ☐		
GP home visit	Yes ☐ No ☐		
District nurse	Yes ☐ No ☐		
Health visitor	Yes ☐ No ☐		
Community-based Occupational Therapist	Yes ☐ No ☐		
Community-based Physiotherapist	Yes ☐ No ☐		
Macmillan social worker	Yes ☐ No ☐		
Palliative care social worker	Yes ☐ No ☐		
Counsellor	Yes ☐ No ☐		
Home help or care worker	Yes ☐ No ☐		
Citizens advice or welfare rights advisor	Yes ☐ No ☐		
Psychiatrist or psychologist	Yes ☐ No ☐		
Food, medicine or laundry delivery service	Yes ☐ No ☐		
Family or patient support or self help groups	Yes ☐ No ☐		
Other services: Please specify in the boxes and for each service also provide the total number of contacts.	1.	1.	1.
	2.	2.	2.
	3.	3.	3.

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Use of hospital-based care services

2. Please tick the hospital-based care services that you have used <u>during the last 3 months</u> because of your diagnosis. If you have used any of the services then please also provide the hospital name and address and tell us about the number of visits or stays you have had at the hospital.

Type of service	Which services have you used during the last 3 months?	Name and town of hospital	Total number of <u>days' stay</u> during the last 3 months	Total number of <u>visits</u> during the last 3 months
Hospital inpatient stay	Yes ☐ No ☐	Hospital: Town:		
Hospital day centre	Yes ☐ No ☐	Hospital: Town:		
Hospital outpatient clinic	Yes ☐ No ☐	Hospital: Town:		
Hospital accident and emergency department	Yes ☐ No ☐	Hospital: Town:		
Convalescent home	Yes ☐ No ☐			
Nursing home	Yes ☐ No ☐			

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Travel costs & additional expenses

This section is about expenses which you may have had to meet during the last 3 months because of your diagnosis.

3. During the last 3 months, how much do you think you have spent on travel because of your diagnosis?

If you have not spent anything on travel please tick the box: ☐

Type of service	Your spending on travel during the last 3 months. (Fares for public transport, taxis and car park fees.)	If you have used your own car, approximate number of miles travelled during the last 3 months.
GP, surgery visit	£	
District nurse, health visitor or member of community health team	£	
Social worker	£	
Physiotherapy	£	
Occupational therapy	£	
Counsellor	£	
Citizens advice or welfare rights advisor	£	
Psychiatrist or psychologist	£	
Hospital	£	
Day centre	£	
Lunch or social club	£	
Family or patient support or self help groups	£	
Other (please specify):	£	

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4. Have had to meet any major expenses of £50 or more <u>during the last 3 months</u> because of your diagnosis? (Please tick Yes or No.)

Yes ☐ **No** ☐

5. If you have ticked 'Yes' to Question 4, please also describe the expenses that you have had to meet in the table below.

Brief description of item	**Cost to you during the last 3 months**
	£
	£
	£
	£

6. We are interested in how much you have spent on medicines as a result of your diagnosis. This might be prescribed medicines, over the counter medicines or homeopathic or herbal remedies.

During the last 3 months, what medicines have you used as a result of your diagnosis and what was the cost?

Medicine (Copy name from the bottle/packet)	**Cost to you**

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Employment and usual activities

This section is about how your diagnosis has affected your work and usual activities that you do on a regular basis.

7. Please tick the box or boxes for your employment status(es) during the last 3 months. You may tick more than one box, for example you may be in full time employment but have had time off work (sick leave).

Please also tell us which employment status you are currently in.

Employment status	**Which employment status have you been during the last 3 months?**	**Current employment status** *(Please tick one box only)*
Full time employee (more than 30 hours a week)	Yes ☐ No ☐	☐
Part time employee (less than 30 hours a week)	Yes ☐ No ☐	☐
Self-employed	Yes ☐ No ☐	☐
Full or part time training or education	Yes ☐ No ☐	☐
Employee on sick leave	Yes ☐ No ☐	☐
Not in paid employment due to long standing illness or disability	Yes ☐ No ☐	☐
Retired and not in paid employment	Yes ☐ No ☐	☐

8. Have you lost any earnings because of your diagnosis? (Please tick Yes or No.)

Yes ☐ **No** ☐

Please also provide an estimate of your gross amount lost during the last 3 months.
(Gross amount refers to money lost before tax and national insurance has been deducted.)

Gross amount lost **£** ☐

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This section is about your general health following your diagnosis.

9. For each of the five sets of statements below, please tick the one box that best describes your own health state today.

(i) Mobility

I have no problems in walking about..... ☐

I have some problems in walking about ..... ☐

I am confined to bed ..... ☐

(ii) Self-care

I have no problems with self-care..... ☐

I have some problems washing and dressing myself..... ☐

I am unable to wash or dress myself..... ☐

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

I have no problems with performing my usual activities..... ☐

I have some problems with performing my usual activities.... ☐

I am unable to perform my usual activities..... ☐

(iv) Pain/discomfort

I have no pain or discomfort..... ☐

I have moderate pain or discomfort..... ☐

I have extreme pain or discomfort..... ☐

(v) Anxiety/depression

I am not anxious or depressed..... ☐

I am moderately anxious or depressed..... ☐

I am extremely anxious or depressed..... ☐

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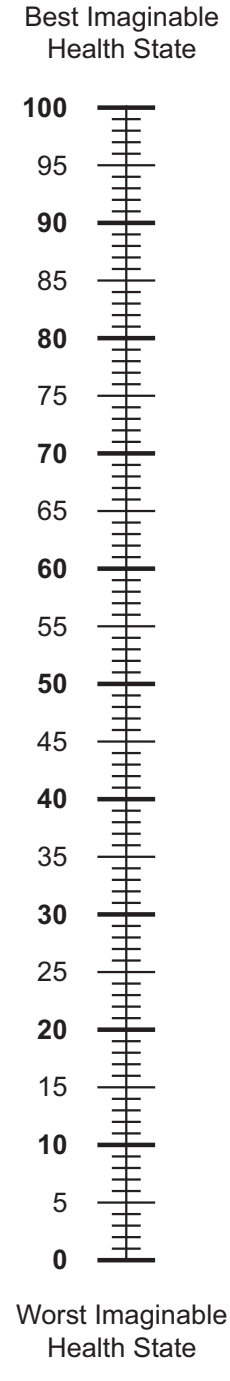
(vi) Health State Scale

To help people say how good or bad their health is, we have drawn a scale (rather like a thermometer) on which the best health state you can imagine is marked 100 and the worst health state you can imagine is marked 0.

We would like you to indicate on this scale how good or bad you think your own health is today. Please do this by drawing a line from the box below to whichever point on the scale indicates how good or bad your health state is today.

Your own health state today



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General health

10. Finally, some questions about your health in general.

(i) In general, how would you say your health is?

Excellent	Very good	Good	Fair	Poor
☐	☐	☐	☐	☐

(ii) The following questions are about activities you might do during a typical day. Does **your health now limit you** in these activities? If so, how much?

	Yes, limited a lot	Yes, limited a little	No, not limited at all
a **Moderate activities**, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf	☐	☐	☐
b Climbing **several** flights of stairs	☐	☐	☐

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(iii) During the **past 4 weeks**, how much of the time have you had any of the following problems with your work or other regular daily activities **as a result of your physical health?**

	All of the time	Most of the time	Some of the time	A little of the time	None of the time
a **Accomplished less** than you would like	☐	☐	☐	☐	☐
b Were limited in the **kind** of work or other activities	☐	☐	☐	☐	☐

(iv) During the past **4 weeks**, how much of the time have you had any of the following problems with your work or other regular daily activities **as a result of any emotional problems** (such as feeling depressed or anxious)?

	All of the time	Most of the time	Some of the time	A little of the time	None of the time
a **Accomplished less** than you would like	☐	☐	☐	☐	☐
b Did work or other activities **less carefully than usual**	☐	☐	☐	☐	☐

(v) During the past **4 weeks**, how much did pain interfere with your normal work (including both work outside the home and housework)?

Not at all	A little bit	Moderately	Quite a bit	Extremely
☐	☐	☐	☐	☐

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(vi) These questions are about how you feel and how things have been with you **during the past 4 weeks**. For each question, please give the one answer that comes closest to the way you have been feeling. How much of the time during the **past 4 weeks**…

		All of the time	Most of the time	Some of the time	A little of the time	None of the time
a	Have you felt calm and peaceful?	☐	☐	☐	☐	☐
b	Did you have a lot of energy?	☐	☐	☐	☐	☐
c	Have you felt downhearted and low?	☐	☐	☐	☐	☐

(vii) During the **past 4 weeks**, how much of the time has your **physical health or emotional problems** interfered with your social activities (like visiting with friends, relatives, etc.)?

All of the time	Most of the time	Some of the time	A little of the time	None of the time
☐	☐	☐	☐	☐

Thank you for completing this questionnaire.

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