Section 3 —Olerud-Molander Ankle Score (OMAS)

The following questions are designed to assess the problems which your ankle injury may be causing you. Please circle the appropriate score.

PARAMETER	DEGREE	SCORE
1) Pain	None	25
	Walking on an uneven surface	20
	Walking on an even surface	10
	Walking indoors	5
	Constant and severe	0
2) Stiffness	None	10
	Stiffness	0
3)Swelling	None	10
	Only evenings	5
	Constant	0
4) Stairs	No problems	10
	Impaired	5
	Impossible	0
5)Running	Possible	5
	Impossible	0
6) Jumping	Possible	5
	Impossible	0
7)Squatting	No Problems	5
	Impossible	0
8) Supports	None	10
	Taping/ Wrapping	5
	Crutches	0
9) Daily Life	Same as before	20
	Loss of tempo	15
	Change of occupation	10
	Severely impaired work capacity	0

Section 4—Social

In order to evaluate the cost-effectiveness of the intervention, the following questions help us to calculate the total cost of the treatment.

1. Other support from government benefits

Are you receiving any of the below? Yes ☐ No ☐

If No, go to question 2

If **Yes**, can you please tick all benefits you have received **in the last three months** and how much you currently receive in benefits each week?

Benefit	**Tick**	**£ per week**	**Benefit**	**Tick**	**£ per week**
Attendance Allowance			Income Support		
Carer's Allowance			Jobseeker's Allowance		
Child Tax Credit			Pension Credit		
Council Tax Benefit			Statutory Sick Pay		
Disability Living Allowance—caring			State Pension		
Disability Living Allowance—mobility			Other..................................		
Employment and Support Allowance			Other..................................		
Housing Benefit			Other..................................		

2. How would you best describe your living arrangements? (Tick one box only)

Live alone ☐
Live with relatives ☐
Live with wife/husband/partner ☐
Live with friends ☐
Care home ☐
Other ☐ Details.......................................

Section 5—Complications

Section 5A: Trial leg wound complications

1. Have you had any problems with the healing of your wound in the last 3 months? Yes ☐ No ☐

If you have answered Yes, please answer **question 2-6**
If you have answered No, please continue with **question 7**

2. Has there been any discharge or fluid leaking from any part of the wound? Yes ☐ No ☐

If Yes, was it either:			
	clear or blood stained ?	Yes ☐	No ☐
	yellow/green (pus)?	Yes ☐	No ☐

3. Please tick any of the following additional symptoms that applied to your wound in the last 3 months:

Increasing pain or discomfort in the area around the wound	Yes ☐	No ☐
Redness or inflammation spreading from the edges of the wound	Yes ☐	No ☐
The area around the wound became increasingly swollen	Yes ☐	No ☐
The edges of any part of the wound separated or gaped open	Yes ☐	No ☐

4. Please tell us the date you noticed these symptoms: (if you are unsure of the exact date please give month and year) d d / m m m / y y y y

5. Did any health care worker take a sample from your wound to send it to the laboratory? Yes ☐ No ☐

6. Were you prescribed antibiotics for these symptoms? Yes ☐ No ☐
If yes, please specify in the next section, **Section 6 -Medications**

Section 5B: All other complications

In the last 3 months have you been treated for any of the following events: (Tick all that apply)

7. Further surgery because of your fracture	Yes ☐	No ☐
8. DVT (Deep Vein Thrombosis)	Yes ☐	No ☐
If **Yes**, did you see the DVT nurse?	Yes ☐	No ☐
Were you prescribed medication for the **DVT**? **If yes, please specify** in **Section 6—Medications**	Yes ☐	No ☐
9. Any other complications	Yes ☐	No ☐

If **Yes, please specify** ....

10. Have you had any other unscheduled appointment at hospital for your fracture? Yes ☐ No ☐

Section 6—Resource Use

Please think back over the times that you have used the NHS **in the last three months** . If you are unsure about any answer please write in your best recollection.

1. Inpatient care

In the last three months, have you been **admitted** to hospital again? Yes ☐ No ☐

If **Yes**, please tell us which department of the hospital you went to (speciality) and the number of days you were in hospital. If the speciality is not listed, then please write in the reason or part of your body as best you can.

Speciality	Name of Hospital and Ward	Number of days in hospital
Orthopaedics (your leg)		
Orthopaedics (any other bones)		
Rehabilitation unit		
For any other surgery? Details:		
For any other non-surgical reason? Details:		

2. Outpatient care

In the last three months, have you made any visits to the hospital or a clinic as an **outpatient?** Yes ☐ No ☐

If **Yes**, please indicate which part of the hospital you went to (speciality). If you don't know which speciality it was, or if it's not listed, then write in the reason or part of your body as best you can.

Speciality	Examples		Number of visits
Orthopaedics	Seeing a surgeon about your fracture, changes to plaster or aids (e.g. splint/braces)		
Pathology	For blood tests		
Radiology	For 1. X-rays 2. MRI scan 3. CT scan		X-rays: MRI scan: CT scan:
Physiotherapy (NHS)	Physiotherapy appointment at the hospital to see an NHS physiotherapist		
Physiotherapy (Private)	Physiotherapy appointment to see a private physiotherapist	What was the total cost to you £...............	
Emergency Department	Related to your fracture or wound		
Emergency Department	Any other reason		
Others: Details			

3. Community Health care

In the last 3 months, have you seen any **health** professionals in the community **because of your fracture?** Yes ☐ No ☐

If **Yes**, please indicate the type of professional, how you were in contact, how often you saw them and how long this was for in total. If the person isn't listed then feel free to write this in.

Type of professional	Number of contacts in last 3 months	Average duration of contacts (minutes)
GP visits in surgery		
GP home visits		
GP telephone contacts		
Practice nurse contacts		
District nurse contacts		
Community physiotherapy contacts		
Occupational therapy contacts		
Other community health professionals (Please specify)..		

4. Medications

In the last 3 months, have you been prescribed or bought any **new medication?** Yes ☐ No ☐

If **Yes**, please note all such medications (including pain relief) below:

Medication Type	Name	Dosage (Please circle/ record the dosage you receive)	No. times daily	No. of days used
Analgesics	Paracetamol	250mg, 500mg		
	Co-codamol	8/500, 30/500		
	Codeine	15mg, 30mg, 60mg		
Other (Please specify)				
Antibiotics	Flucloxacillin	500mg		
Other (Please specify)				
Anti-inflammatory	Ibuprofen	200mg, 400mg, 600mg		
	Naproxen	250mg, 50mg		
	Diclofenac	25mg, 50mg		
Other (Please specify)				
Anti-inflammatory gels/ creams	Oruvail gel			
Other (Please specify)				
Deep Vein Thrombosis (DVT) medication	Warfarin			
Other (Please specify)				
Other Medication (Please specify)				

5. Personal social services

In the last three months, have you been provided with personal social services to make your day to day life easier to manage? Yes ☐ No ☐

If **Yes**, in the following table, please indicate the number of contacts with the service and the average duration of these contacts in minutes. If the type of support you have received isn't listed then feel free to write this in.

Other support	How many times?	Average duration of contacts (minutes)
Meals on wheels (frozen, daily)		
Meals on wheels (hot, daily)		
Laundry services		
Social worker contacts		
Care worker contacts including help at home		
Other Social Services (Please specify)		
Other (Please specify)		

6. Aids and adaptations

In the last three months, have you received or bought any aid or adaptation? Yes ☐ No ☐

If Yes, in the following table, please indicate the number of aids or the items of equipment received. If an item you have received isn't listed then feel free to write this in and the quantity.

Aids and adaptation	Number received	Cost if bought yourself (£)
Crutches		
Stick		
Zimmer frame		
Grab rail		
Dressing aids		
Long-handle shoe horn		
Other		
Other		

In order to evaluate the cost-effectiveness of the intervention, the following questions help us to calculate the total cost of the treatment.

7. Time off work

Are you currently working? Yes ☐ No ☐

If no, is this: Because of your lower leg fracture ☐

Because of other health reasons ☐

Because you are retired or unable to work for other reasons ☐

In the **last 3 months,** have you taken **time off work** or **lost any income** because of your lower leg fracture?

Yes ☐ **No** ☐ **N/a** ☐

If **Yes,** please provide details below:

If **Yes**, how many days? ☐ Income lost (£) ☐

8. Additional information

In the last three months, have you or your partner and relatives incurred any additional costs as a result of your contact with health or social care services or your general health state?

Yes ☐ No ☐

If **Yes,** please list below in the following table:

Costs	Cost to you (£)	Cost to partner or relatives (£)
Travel costs (Bus, train, taxi, car)		
Child care costs		
Help with housework		
Other: Details …………………………………………		
Other: Details …………………………………………		

Section 7

1. Since leaving hospital do you feel? (Tick one box only)

Substantially Better ☐
Moderately Better ☐
No Different ☐
Moderately Worse ☐
Substantially Worse ☐

2. How satisfied were you with the treatment you received? (Tick one box only)

Extremely Satisfied ☐
Very Satisfied ☐
Somewhat Satisfied ☐
Neither Satisfied nor Dissatisfied ☐
Somewhat Dissatisfied ☐
Very Dissatisfied ☐
Extremely Dissatisfied ☐

3. Have your contact details changed or likely to change in the next six months?

Yes ☐ No ☐

If **Yes**, please provide your new contact details on the **following page**.

FIxDT

Centre ID: [| |] Participant ID: [| | |]

Please complete your new contact details below:

House/Flat number: ....
Street Name: ....
....
Town/City: ....
Postcode: ....
Email: ....

Telephone
Home: ....
Work: ....
Mobile: ....
Preferred method/time of contact: ....

Date new details effective from: [d | d] [m | m | m] [y | y | y | y]

That is the end of the questionnaire.

Please check that you have completed all sections.

We will send you another questionnaire in six months. In the meantime, please keep a record of any days off work, hospital or GP visits, medication, use of special equipment or support you may receive as a result of your fracture.

Please write any notes you have for us in the space overleaf and return the questionnaire in the reply-paid envelope provided.

Thank you very much for your time.