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CASE REPORT FORMS

GAPS

Patient Initials ☐☐☐ Subject No. ☐☐☐

Site no. ☐☐

CRF INDEX GUIDE (for printing)

SCREENING

Screening Date __ __ / __ __ __ / __ __ __ __ (DD / MMM / YYYY)

Initials: __ __ __ **(If no middle initial please use a dash)**

Age: __ __

Sex: ☐ Male ☐ Female

Operation _____

Department _____ (vascular / general / orthopaedics /urology / neurosurgery / obs & gyn / ENT etc)

Reason for exclusion:

☐ Age < 18

☐ Unable to give informed consent / Lack of Capacity

☐ Contraindications to low molecular weight heparin (LMWH)

☐ Contraindications to GCS (e.g. peripheral arterial disease, stroke patients, individuals undergoing lower limb surgery) *lower limb surgery alone is not an exclusion only if contraindicated

☐ Documented or known thrombophilia or thrombogenic disorder

☐ Individuals requiring therapeutic anticoagulation

☐ Previous venous thromboembolism (VTE)

☐ Patients having intermittent pneumatic compression (IPC) beyond theatre and recovery

☐ Patients requiring inferior vena cava (IVC) filter

☐ Pregnancy (female participants of reproductive age will be eligible for inclusion in the trial, subject to a negative pregnancy test prior to randomisation)

☐ Patients requiring thromboprophylaxis to be extended beyond discharge

☐ Application of a cast or brace in theatre

☐ Clinician decision (please specify) _____

☐ Declined study (please specify reason if willing) _____

☐ Day case (would not receive LMWH)

☐ Patient missed ☐ Other (please specify) _____

Inclusion / Exclusion Checklist

Inclusion Criteria

The following criteria MUST be answered YES for participant to be included in the trial (except where NA is appropriate):		Yes	No
1.	Elective surgical inpatients assessed as being at moderate or high risk of VTE according to the widely-used UK Department of Health VTE Risk Assessment for Venous Thromboembolism (or the Trust equivalent based on this form	☐	☐
2.	Patient age ≥ 18 years	☐	☐
3.	Able to give informed consent to participate in the study after reading the patient information	☐	☐
If any of the above criteria is answered NO, the participant is NOT eligible for the trial and must not be included in the study.			

Exclusion Criteria

The following criteria MUST be answered NO for the participant to be included in the trial:		Yes	No
1.	Is there a contraindication to low molecular weight heparin (LMWH)	☐	☐
2.	Is there a contraindication to GCS, including peripheral arterial disease, stroke patients, individuals undergoing lower limb surgery	☐	☐
3.	Is there a documented or known thrombophilia or thrombogenic disorder	☐	☐
4.	Do they require therapeutic anticoagulation	☐	☐
5.	Have they had a previous venous thromboembolism	☐	☐
6.	Do they require intermittent pneumatic compression (IPC) beyond theatre and recovery	☐	☐
7.	Do they require an inferior vena cava (IVC) filter	☐	☐
8.	Do they require thromboprophylaxis to be extended beyond discharge	☐	☐
9.	Do they intend to apply a cast or brace in theatre	☐	☐
10.	Female only: Is the patient pregnant	☐	☐
If any of the above criteria is answered YES, the participant is NOT eligible for the trial and must not be included in the study.			

Signed_____ Dated _____

PATIENT CONSENT

Participant Informed Consent:	
Date participant signed written consent form:	__ __ / __ __ __ / __ __ __ __ (DD / MMM / YYYY)
Name of person taking informed consent: _____	

PREGNANCY (IF FEMALE)

☐ Date of Test	__ __ / __ __ __ / __ __ __ __ **(DD / MMM / YYYY)**
Result	☐ **N/A - Not of child bearing potential** ☐ **Negative** ☐ **Positive = DO NOT RANDOMISE**

RANDOMISATION

Participant Randomisation/Enrolment	
Participant study Number allocated:	____ ____ ____ ____ ____
Treatment Arm	☐ **GCS + LMWH** ☐ **LMWH Alone**

GIVE PATIENT QUESTIONAIRES (BEFORE PT TOLD OF TREATMENT ALLOCATION)

EQ-5D

Also provide patient with:

- **Patient Diary**
- **Patient Contact Card**
- **Patient stocking compliance diary**

PATIENT CONTACT FORM

Title_____
Patient First name_____
Patient First Last name_____
Patient address **Address 1**_____ **Address 2**_____ **Address 3**_____ **Address 4**_____ **Post code**_____
Patient email _____@_____ ☐ **Not Collected**
Patient telephone no._____
Patient mobile no. _____
Preferred method of contact for questionnaire ☐ **Online** ☐ **Mail** ☐ **Telephone**

VISIT 1 BASELINE **VTE SCORE**

Date of Assessment: __ __ / __ __ __ / __ __ __ __

(DD / MMM / YYYY)

Department of Health risk assessment for venous thromboembolism (VTE)

Thrombosis risk	
Patient related	**Admission related**
☐ Active cancer or cancer treatment	☐ Significantly reduced mobility for 3 days or more
☐ Age >60	☐ Hip or knee replacement
☐ Dehydration	☐ Hip fracture
☐ Known thrombophilias*	☐ Total anaesthetic & surgical time > 90 minutes
☐ Obesity (BMI . 30kg.m^2)	☐ Surgery involving pelvis or lower limb with a total anaesthetic & surgical time > 60 minutes
☐ One of more significant medical comorbidities (e.g. heart disease; metabolic endocrine or respiratory pathologies; acute infectious diseases; inflammatory conditions)	☐ Acute surgical admission with inflammatory or intra-abdominal condition
☐ Personal history* or first degree relative with a history of VTE	☐ Critical care admission
☐ Use of hormone replacement therapy	☐ Surgery with significant reduction in mobility
☐ Use of oestrogen-containing therapy	
☐ Varicose veins with phlebitis	
☐ Pregnancy* or < 6 weeks post partum (see NICE guidance for specific risk factors)	
Final Score_____	

*If ticked the patient would not be eligible for GAPS.
0 ticks = low risk (not eligible for GAPS) 1 tick = medium risk & >1 tick – high risk (eligible)

Bleeding risk	
Patient related	**Admission related**
☐ Active bleeding	☐ Neurosurgery, spinal surgery or eye surgery
☐ Acquired bleeding disorders (such as acute liver failure)	☐ Other procedure with high bleeding risk
☐ Concurrent use of anticoagulants known to increase the risk of bleeding (such as warfarin with INR>2)	☐ Lumbar puncture/epidural/spinal anesthesia expected within the next 12 hours
☐ Acute stroke	☐ Lumbar puncture/epidural/spinal anesthesia expected within the previous 4 hours
☐ Thrombocytopaenia (platelets< 75x10^9/L)	
☐ Uncontrolled systolic hypertension (230/120 mmHg or higher)	
☐ Untreated inherited bleeding disorders (such as haemophilia and von Willebrand's disease	

VISIT 1 BASELINE **CAPRINI SCORE**

Date of Assessment: __ __ / __ __ __ / __ __ __ __

(DD / MMM / YYYY)

Add 1 point for each of the following statements that apply now or within the past month		**Add 2 points for each of the following statements that apply**
☐ Age 41 - 60 years		☐ Age 61-74 years
☐ Minor surgery (less than 45 minutes) is planned		☐ Current or past malignancies (excluding skin cancer, but not melanoma)
☐ Past major surgery (more than 45 minutes) within the last month		☐ Planned major surgery lasting longer than 45 minutes (including laparoscopic and arthroscopic)
☐ Visible varicose veins		☐ Non-removable plaster cast or mold that has kept you from moving your leg within the last month
☐ A history of Inflammatory Bowel Disease (IBD) (for example. Crohn's disease or ulcerative colitis)		☐ Tube in blood vessel in neck or chest that delivers blood or medicine directly to heart within the last month (also called central venous access, PICC line, or port)
☐ Swollen legs (current)		☐ Confined to a bed for 72 hours or more
☐ Overweight or obese (Body Mass Index above25)		
☐ Heart attack		**Add 3 points for each of the following statements that apply**
☐ Congestive heart failure		☐ Age 75 or over
☐ Serious infection (for example pneumonia)		☐ History of blood clots, either Deep Vein Thrombosis (DVT) or Pulmonary Embolism (PE)
☐ Lung disease (for example emphysema or COPD)		☐ Family history of blood clots (thrombosis)
☐ On bed rest or restrictive mobility, including a removable leg brace for less than 72 hours		☐ Personal or family history of positive blood test indicating an increased risk of blood clotting
☐ Other risk factors (1 point each)*** ***Additional risk factors not tested in the validation studies but shown in the literature to be associated with thrombosis include BMI above40, smoking, diabetes requiring insulin, chemotherapy, blood transfusions & length of surgery over 2 hours		
Women only: Add 1 point for each of the following statements that apply		**Add 5 points for each of the following statements that apply now or within the past month**
☐ Current use of birth control or hormone replacement therapy (HRT)		☐ Elective hip or knee joint replacement surgery
☐ Pregnant or had a baby within the last month		☐ Broken hip, pelvis or leg
☐ History of unexplained stillborn infant, recurrent spontaneous abortion (>3), premature birth with toxemia or growth restricted infant		☐ Serious trauma (e.g. multiple broken bones due to fall or an car accident
Caprini Score_____(calculated by database)		☐ Spinal cord injury resulting in paralysis
		☐ Experienced a stroke

Date of Assessment: __ __ / __ __ __ / __ __ __ __

(DD / MMM / YYYY)

VISIT 1 BASELINE **VITAL SIGNS**

Weight: ___ ___ ___ . ___ kg **Height:** ___ . ___ ___ m BMI calculated automatically

BASELINE VISIT **DEMOGRAPHIC DATA**

Date of Birth: __ __ / __ __ __ / __ __ __ __

(DD / MMM / YYYY)

Ethnicity:

White	White British ☐	White Irish ☐	White Other ☐	
Mixed race	White & Black Caribbean ☐	White & Black African ☐	White & Asian ☐	Other mixed background ☐
Asian or Asian British	Indian ☐	Pakistani ☐	Bangladeshi ☐	Other Asian background ☐
Black or Black British	Caribbean ☐	African ☐	Black Other ☐	
Chinese or other ethnicity	Chinese ☐	Other ☐ **(**please specify**)**		

Sex: ☐ Male ☐ Female

Work: Is the patient retired? ☐ Yes ☐ No

If no, : Worker ☐ **employee** ☐ **self-employed** ☐ **contractor** ☐ **director** ☐ **office holder** ☐ **unemployed** ☐ **student**

Occupation_____

VISIT 1 BASELINE **LIFE STYLE**

Smoker: ☐ **Never** ☐ **Ex-smoker** ☐ **<1 year** ☐ **<5 years** ☐ **> 5 years** ☐ **Current Smoker : _____ per day**

Alcohol consumption: : ☐ **Never** ☐ **Ex drinker** ☐**Current drinker: _____ units per week**

Diet: ☐ **Vegetarian** ☐ **Low Meat Diet** ☐ **High Meat Diet (>90g day)**

Physical Activity level: ☐ **Low** ☐ **Moderate**** ☐ **Vigorous*****

walking/ water aerobics/ ballroom and line dancing/ riding a bike on level ground or with few hills/ playing doubles tennis/ pushing a lawn mower/ canoeing/ volleyball – 150 minutes a week*jogging or running/ aerobics/ swimming fast/ riding a bike fast or on hills/ singles tennis/ football/ hiking uphill/ energetic dancing/ martial arts – 75 minutes a week

VISIT 1 (BASELINE) **MEDICATIONS**

Women only : Current use of Oral Contraceptives	☐ No ☐ Yes
Women only : Current use of Post menopausal hormones	☐ No ☐ Yes
Anti-Inflammatory Drugs	☐ No ☐ Yes
Statins	☐ No ☐ Yes
Currently taking Antiplatelet therapy	☐ **None** ☐ **Single** ☐ **Dual** ☐ **Triple**
Other Medication	☐ **Others:** _____

VISIT 1 (BASELINE) **MEDICAL HISTORY**

History of Malignancy	☐ No ☐ Yes if yes_____
Past Surgical History	☐ No ☐ Yes if yes_____
Past Medical History	☐ Previous myocardial infarction ☐ Previous stroke ☐ Treated hypertension ☐ Other relevant history_____ ☐ None
Previous Pregnancies	☐ No ☐ Yes

VISIT 1 (BASELINE) **SURGERY DETAILS**

Actual date of surgery	__ __/ __ __ __/ __ __ __ __ (DD / MMM / YYYY)
Was the patient still eligible on the date of surgery?	☐ Yes ☐ No, please state why_____
Anaesthetic	☐ General ☐ Regional ☐ Both ☐ Other
Which stockings were the patient prescribed?	☐ N/A – randomised to LMWH alone ☐ Above knee stocking ☐ Below knee stocking

TELEPHONE FOLLOW UP – PATIENT CONTACT ATTEMPT FORM

Please document all attempts to contact the patient during the 90 day follow-up period	If you could not speak to the patient on this attempt, please document if message left with relative / voicemail / number no longer works etc.
Date of Call __ __ / __ __ __ / _2_ 0 __ __ (DD / MMM / YYYY) **Time of call:** __ __ : __ __ **(24:00)**	
Date of Call __ __ / __ __ __ / _2_ 0 __ __ (DD / MMM / YYYY) **Time of call:** __ __ : __ __ **(24:00)**	
Date of Call __ __ / __ __ __ / _2_ 0 __ __ (DD / MMM / YYYY) **Time of call:** __ __ : __ __ **(24:00)**	
Date of Call __ __ / __ __ __ / _2_ 0 __ __ (DD / MMM / YYYY) **Time of call:** __ __ : __ __ **(24:00)**	
Date of Call __ __ / __ __ __ / _2_ 0 __ __ (DD / MMM / YYYY) **Time of call:** __ __ : __ __ **(24:00)**	
Date of Call __ __ / __ __ __ / _2_ 0 __ __ (DD / MMM / YYYY) **Time of call:** __ __ : __ __ **(24:00)**	
Date of Call __ __ / __ __ __ / _2_ 0 __ __ (DD / MMM / YYYY) **Time of call:** __ __ : __ __ **(24:00)**	
Date of Call __ __ / __ __ __ / _2_ 0 __ __ (DD / MMM / YYYY) **Time of call:** __ __ : __ __ **(24:00)**	

FOLLOW-UP VISIT 1
DISCHARGE OR 1 WEEK (WHICHEVER IS EARLIEST)

Date of Assessment: __ __ / __ __ __ / __ __ __ __

(DD / MMM / YYYY)

Visit ☐ Hospital Discharge ☐ 1 week

Visit ☐ In person ☐ Over the telephone

Any VTE symptoms:

☐ **None**

☐ **Yes DVT: If yes, complete:** ☐ **Leg swelling** ☐ **Calf Pain** ☐ **Other**_____

☐ **Yes PE: If yes, complete:** ☐ **Shortness of breath** ☐ **Chest pain** ☐ **Haemoptysis** **Other**_____

Diagnosis of VTE confirmed ☐ **No**

☐ **Yes If yes, complete:** ☐ **DVT** ☐ **PE** ☐ **DVT & PE**

(Please also complete the VTE form)

Did the patient receive LMWH i.e. all prescribed doses & times

☐ **Yes**

☐ **No If no, complete: How many doses missed** ____**out of** _____ **prescribed**

Reason dose/s missed_____

If the patient remains in hospital post 1 week, please collect LMWH compliance for the entire admission.

Were there any adverse events related to LMWH / GCS during the admission? (If yes, please record on Adverse Events Form)	☐No	☐Yes
Were there any serious adverse events during the admission? (If yes, please record on Serious Adverse Events Form)	☐No	☐Yes

FOLLOW-UP VISIT 2
DUPLEX CLINIC VISIT (14 to 21 days post surgery)
PLEASE FORWARD ANONMYSED DUPLEX REPORT TO TRIALS UNIT

ANONMYSED DUPLEX REPORT SENT TO TRIALS UNIT ☐ Yes ☐ No If no, _____

Date of duplex report_____

Right Leg

Duplex Evidence of VTE ☐ **No**

☐ **Yes If yes, complete location (tick all that are relevant):**

- ☐ **Below Knee (Calf / Distal popliteal)**
  - ☐ **Single calf vessel**
  - ☐ **>1 calf vessel**
  - ☐ **distal popliteal vein**
- ☐ **Above knee (Femoral / Proximal popliteal)**
- ☐ **Above the inguinal ligament (iliac vein)**

(Please also complete the VTE form)

Left Leg

Duplex Evidence of VTE ☐ **No**

☐ **Yes If yes, complete location (tick all that are relevant):**

- ☐ **Below Knee (Calf / Distal popliteal)**
  - ☐ **Single calf vessel**
  - ☐ **>1 calf vessel**
  - ☐ **distal popliteal vein**
- ☐ **Above knee (Femoral / Proximal popliteal)**
- ☐ **Above the inguinal ligament (iliac vein)**

(Please also complete the VTE form)

Were there any adverse events related to LMWH / GCS since discharge? (If yes, please record on Adverse Events Form)	☐No	☐Yes
Were there any serious adverse events since discharge? (If yes, please record on Serious Adverse Events Form)	☐No	☐Yes
What was the cost of patient travel?	£___. ___ ☐ not claimed	

FOLLOW-UP VISIT 3
90 DAYS POST SURGERY

Date of Assessment: __ __ / __ __ __ / __ __ __ __

(DD / MMM / YYYY)

Visit ☐ In person ☐ Over the telephone ☐ From Hospital notes

Any VTE symptoms since the last visit / phone call:

☐ **None**

☐ **Yes DVT: If yes, complete:** ☐ **Leg swelling** ☐ **Calf Pain** ☐ **Other**_____

☐ **Yes PE: If yes, complete:** ☐ **Shortness of breath** ☐ **Chest pain** ☐ **Haemoptysis** **Other**_____

Diagnosis of VTE confirmed ☐ **No**

☐ **Yes If yes, complete:** ☐ **DVT** ☐ **PE** ☐ **DVT & PE**

(Please also complete the VTE form)

Were there any adverse events related to LMWH / GCS since follow-up 2? (If yes, please record on Adverse Events Form)	☐No	☐Yes
Were there any serious adverse events since follow-up 2? (If yes, please record on Serious Adverse Events Form)	☐No	☐Yes

VTE FORM

Date VTE identified: __ __ / __ __ __ / __ __ __ __

(DD / MMM / YYYY)

☐ Imaging-confirmed Symptomatic DVT

☐ Asymptomatic DVT identified by duplex

☐ Imaging-confirmed symptomatic PE

Please forward a copy of the anonymised duplex report to the trials unit ☐ **Report sent**

ADVERSE EVENT FORM

Adverse Event Description	Related to GCS: ☐ Discomfort ☐ Skin break / ulcer ☐ Skin necrosis, ☐ Skin Blistering ☐ Skin Rash ☐ Limb ischaemia ☐ Other AE of interest _____ Related to LMWH (during admission or within 24 hours of discharge): ☐ Bleeding complication ☐ Rash / skin change tests ☐ Allergic reaction ☐ Thrombocytopenia, ☐ Abnormal liver enzyme ☐ Other AE of interest_____
Onset Date	__ __ / __ __ __ / 2 0 __ __ (DD / MMM / YYYY)
Ongoing	☐ Yes ☐ No: end date __ __ / __ __ __ / 2 0 __ __ (DD / MMM / YYYY)
Treatment for AE	_Please state_____
Outcome	☐ Recovered ☐ Not yet recovered ☐ Unknown ☐ Fatal (please complete an SAE form)
AE Additional Details	Please state_____ _____ _____

SERIOUS ADVERSE EVENT FORM

Serious Adverse Event Description	**Please state**_____
Serious reason	☐Death ☐Life threatening ☐ Persistently disabling ☐Hospitalisation required ☐Congenital abnormality ☐Other medical important event: detail_____
Onset Date	__ __ / __ __ __ / 2 0 __ __ (DD / MMM / YYYY)
Treatment for SAE	_Please state_____
Frequency	☐Single Episode ☐Intermittent ☐Frequent ☐Continuous ☐Unknown
Severity	☐ Mild (aware of it easily tolerated) ☐ Moderate (discomfort/interference with usual activity) ☐ Severe (inability to carry out normal activity) ☐ Life threatening or disabling
Relationship to LMWH or GCS (LOCAL PI MUST ASSESS RELATIONSHIP)	☐**Not related** (no evidence of a causal relationship between LMWH / GCS and event). ☐**Unlikely** (there is little evidence (e.g. event did not occur within a reasonable time). There is another reasonable explanation for the event (e.g. clinical condition, concomitant treatment). ☐**Possible** (there is some evidence (e.g. event occurs within a reasonable time). However, there may be other factors (e.g. clinical condition, other concomitant treatments) ☐**Probable** (there is evidence to suggest a causal relationship. Other factors are unlikely. ☐**Definite** (there is clear evidence to suggest a causal relationship. Other factors can be ruled out)
If Related, assess expectedness in relation to LMWH / GCS	☐Expected ☐Unexpected **(PI MUST ASSESS EXPECTEDNESS)**
Details of any intervention required / any further information	**Please state**_____
Ongoing	☐Yes ☐No: end date __ __ / __ __ __ / 2 0 __ __ (DD / MMM / YYYY)
Outcome	☐Recovered ☐Not yet recovered ☐Fatal ☐Unknown

Principal Investigator Signature (to confirm review and assessment of SAE)	_PI SIGN_____DATE_____

CI use only

Does CI agree with the local PI assessment?	☐Yes ☐No (if not please complete below)

If no, CI relatedness	☐**Not related** (no evidence of a causal relationship between LMWH / GCS and event). ☐**Unlikely** (there is little evidence (e.g. event did not occur within a reasonable time). There is another reasonable explanation for the event (e.g. clinical condition, concomitant treatment). ☐**Possible** (there is some evidence (e.g. event occurs within a reasonable time). However, there may be other factors (e.g. clinical condition, other concomitant treatments) ☐**Probable** (there is evidence to suggest a causal relationship. Other factors are unlikely. ☐**Definite** (there is clear evidence to suggest a causal relationship. Other factors can be ruled out)

If Related, assess expectedness in relation to LMWH / GCS	☐Expected ☐Unexpected

PROTOCOL DEVIATION FORM

☐ Patient randomised but surgery cancelled _____
☐ Patient Ineligible, if so please detail_____
☐ Patient withdrawn from trial intervention but continues to be followed –up, please state why_____
☐ Late Duplex, if yes, reason_____
☐ Missed Duplex, if yes, reason_____
☐ Late Visit, if yes, reason_____
☐ Missed Visit if yes, reason_____
☐ Patient randomised to 'LMWH alone' but wore stockings
☐ Patient randomised to 'LMWH and stockings' but did not wear stockings at all
☐ Flowtron use beyond theatre and recovery
☐ LMWH not given, unexpectedly discharged early
☐ LMWH not given, clinical decision
☐ LMWH not given, not prescribed
☐ LMWH not given, other reason (please detail)
☐ Other (please detail)_____ _____ _____

CHANGE OF STATUS FORM

Q1. Is this a post-randomisation exclusion? (i.e. the participant was not eligible for the study)	☐ **Yes, please state reason:** _____ ☐ **No (Go to Q2)**

Q2. Please provide change of status date:

__ __ / __ __ __ / _2_ 0 __ __

(DD / MMM / YYYY)

Q3. Is this change of status as a result of:

☐ **Death**

☐ **Loss to follow-up (patient cannot be contacted)**

☐ **Patient withdrawal:**

Q4. Who requested the change of status?

☐ **Participant**

☐ **Clinician**

☐ **Other, please state**_____

Q5. Which of the following is the participant withdrawing from? (tick as many boxes as required)

☐ **Trial treatment arm, please detail:** _____

☐ **Attending follow-up clinics**

☐ **Completing further questionnaires**

☐ **Relevant outcome data being collected via hospital and GP records (only complete if participant explicitly requests this)**

☐ **Contact from study office (telephone / email) excludes the posting of questionnaires** ***delete as appropriate**

EQ-5D-5L

GAPS

Health Questionnaire

English version for the UK

The EQ-5D form must be completed at:

Please tick the relevant box to indicate:

- ☐ **Baseline**
- ☐ **1 week (or hospital discharge)**
- ☐ **Between 14 to 21 days (at your scan)**
- ☐ **At 90 days**

Date of questionnaire completion: ☐☐ ☐☐ ☐☐ **dd/mm/yy**

Visit ☐ In person ☐ Over the telephone

Under each heading, please tick the ONE box that best describes your health TODAY.

Mobility

I have no problems in walking about ❑
I have slight problems in walking about ❑
I have moderate problems in walking about ❑
I have severe problems in walking about ❑
I am unable to walk about ❑

Self-Care

I have no problems washing or dressing myself ❑
I have slight problems washing or dressing myself ❑
I have moderate problems washing or dressing myself ❑
I have severe problems washing or dressing myself ❑
I am unable to wash or dress myself ❑

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

I have no problems doing my usual activities ❑
I have slight problems doing my usual activities ❑
I have moderate problems doing my usual activities ❑
I have severe problems doing my usual activities ❑
I am unable to do my usual activities ❑

Pain/Discomfort

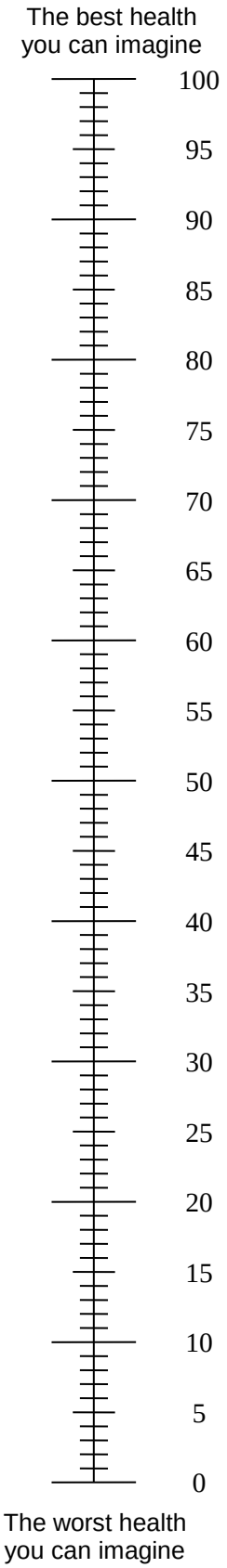
I have no pain or discomfort ❑
I have slight pain or discomfort ❑
I have moderate pain or discomfort ❑
I have severe pain or discomfort ❑
I have extreme pain or discomfort ❑

Anxiety/Depression

I am not anxious or depressed ❑
I am slightly anxious or depressed ❑
I am moderately anxious or depressed ❑
I am severely anxious or depressed ❑
I am extremely anxious or depressed ❑

- We would like to know how good or bad your health is TODAY.
- 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 your health is TODAY.
- Now, please write the number you marked on the scale in the box below.

YOUR HEALTH TODAY = ☐



Patient Diary

*** To be completed by the patient ***

As part of the GAPS study we would like to collect information about any encounters with health professionals you may have had.

We hope that **you can complete this diary** every time you see a health professional to help us collect this information.

Please complete a section in this diary for
EVERY time you **see or speak** to a health professional:

- Hospital appointments or admissions
- GP Clinic or Home Visits
- Telephone calls with a health professional
- Any scans or tests

SITE ID:_____

PATIENT ID:_____

PATIENT ID:_____

Please complete every section(s) below for each appointment or telephone conversation:

Date _____/_____/_____

1) Did you have any planned appointments from your doctor following your surgery:

- ☐ **Yes (please state what e.g. routine follow-up)_____**
- ☐ **No**

2) Reason(s) for seeing a medical professional:

- ☐ **For your leg (s) please state reason_____**
- ☐ **Not for your leg (s) please state reason_____**

3) Was this:

- ☐ **An appointment**
- ☐ **Telephone conversation**
- ☐ **Home visit**

4) Which health professional did you visit or speak to:

- ☐ **Hospital Doctor**
- ☐ **Hospital Nurse**
- ☐ **GP**
- ☐ **GP Practice Nurse**
- ☐ **Other _____**

5) Did you receive any advice or treatment (please complete as many as necessary):

- ☐ **Medical advice: If so what_____**
- ☐ **Blood test (s)**
- ☐ **Scan (s): If so which part of your body_____**
- ☐ **Medication(s): If so what_____**
- ☐ **Other_____**

Stocking Compliance Diary
(Stocking Arm Only)
Date of operation: _____ Date of hospital discharge_____
Please complete this diary as honestly as you can.
It is important that we collect accurate information about when you wear your stockings.
We understand that you may not be able to wear your stockings all of the time.

Day	Date	**Please tick to show when you wore your stockings**					
		I wore my stockings in the **morning**	I wore my stockings in the **afternoon**	I wore my stockings in the **evening**	I wore my stockings at **night (while sleeping)**	Estimated **number of hours** I wore my stockings in a day (total of 24 hours)	**Reason for not wearing stockings**, for example 'discomfort', 'inconvenience' 'forgot'
1						____/24hrs	
2						____/24hrs	
3						____/24hrs	
4						____/24hrs	
5						____/24hrs	
6						____/24hrs	
7						____/24hrs	
8						____/24hrs	
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