Keeping Children Safe: Measuring the cost of children's accidents

These questions ask about how much your child's accident cost you, your family and the NHS in the THIRD and FOURTH WEEKS after the accident and whether your child is getting better.

Part 1. Visits to your GP for your child's accident

1.1 **In the THIRD and FOURTH WEEKS after the accident, how many times has your child visited any of these health professionals at your GP's surgery because of their accident?** *(please put '0' if none)*

	Number of visits
GP	.....
Practice nurse	.....
Other (please say who) _____	.....

Part 2. Visits to other health professionals for your child's accident

2.1 **In the THIRD and FOURTH WEEKS after the accident, how many times has your child visited, or been visited at home by, one of these health professionals because of their accident?** *(please put '0' if none)*

	Number of visits	Treatment site (e.g. home, clinic, name of hospital	Did you pay for this visit?	
			Yes	No
Doctor / Consultant				
Health visitor				
Physiotherapist				
Nurse (Don't include GP visits here)				
Other (please say who)(Don't include visits to Practice Nurse here)				

Part 3. Stays in hospital AND visits to the Day Case Unit for your child's accident

3.1 **In the THIRD and FOURTH WEEKS after the accident, has your child had to stay in hospital overnight or visit a day case unit because of their accident?** *(please ✓ one box)*

☐ Yes – please fill in the table below

☐ No – please go to Section 4

	Admission Date	Discharge Date	Name of the hospital	Name of consultant *(if known)*	Name of ward *(if known)*
Stay 1					
Stay 2					
Stay 3					
Stay 4					
Stay 5					

Part 4. Medicine and medical supplies for your child's accident

4.1 **In the THIRD and FOURTH WEEKS after the accident, has your child taken any PRESCRIBED medicines because of their accident?** *(please ✓ one box)*

☐ Yes – please fill in the table below

☐ No - please go to Section 4.2

Please list all medicines prescribed by a doctor or nurse because of your child's accident.

Name of medicine	**About HOW OFTEN and HOW LONG did your child take this medicine?**
e.g. Paracetamol, Calpol, Nurofen	e.g. four times a day for 2 weeks
1.	
2.	
3.	
4.	
5.	

4.2 **In the THIRD and FOURTH WEEKS after the accident, has your child taken any medicines that were BOUGHT WITHOUT A PRESCRIPTION because of their accident?** *(please ✓ one box)*

☐ Yes – please fill in the table below

☐ No - please go to Section 4.3

Please list all the medicines bought without a prescription because of your child's accident.

Name of medication	**About HOW OFTEN and HOW LONG did your child take this medicine?**
e.g. Paracetamol, Calpol, Nurofen	e.g. four times a day for 2 weeks
1.	
2.	
3.	
4.	
5.	

4.3 **In the THIRD and FOURTH WEEKS after the accident, have you GOT ANY AIDS OR MADE ANY CHANGES to help your child in the home or garden because of their accident?** *(please ✓ one box)*

☐ Yes – please fill in the table below

☐ No – please go to Section 5

Type of Aid/Changes made *(e.g. Wheel chair)*	**Cost of item (if known)**	**Who bought this or gave you this?** *(e.g. (yourself, family, NHS, social services, other)*
1.		
2.		
3.		
4.		
5.		

Part 5. Childcare and other costs

5.1 **In the THIRD and FOURTH WEEKS after the accident, when you took your child who had the accident to see a health professional, did you need to get someone to look after your other children and/or other people you care for? Please only include care they have provided because of the accident, not care they would normally provide.** (*please ✓ one box)*

☐ Yes ☐ No ☐ Not applicable

If YES,

a) Who looked after your children or the other people you care for? *(please ✓ all that apply)*

☐ Relative

☐ Friend

☐ Professional carer *(e.g. childminder)*

b) In total, how long did they look after your children and/or the other people you care for?
..... Days ..... Hours

5.2 **In the THIRD and FOURTH WEEKS after the accident, has your child who had the accident needed extra care that you paid for because of their accident?** *(please ✓ one box)*

☐ Yes ☐ No

If YES,

How many days care did your child have? ..... Days

How many hours care per day? ..... Hours

Part 6. Work and your child's accident

The next questions ask about time off work or usual activities of the people (including yourself) who have cared for your child. Please only include care they have provided because of the accident, not care they would normally provide.

During the THIRD and FOURTH WEEKS after the accident, please think about the 2 people who do most of the caring for your child. Call these people carer 1 and carer 2. One of these people may be you. Please fill in the box below:

The 2 people who care most for your child	**Carer 1**	**Carer 2**
What is the relationship of this person to your child?	☐ Parent ☐ Relative (not parent) ☐ Friend ☐ Other *(please describe)*	☐ Parent ☐ Relative (not parent) ☐ Friend ☐ Other *(please describe)*
Total number of days taken off work or usual activities by this person to care for your child in the **THIRD and FOURTH WEEKS** after the accident. Only include care provided because of the accident. E.g. if you took 4 days off in week THREE and grandmother took 3 days off in week FOUR you would write "4" in the carer 1 box and "3" in the carer 2 box.	..... Days	..... Days
Did this person lose any money from work because they were caring for your child?	☐ Yes ☐ No	☐ Yes ☐ No
Sex of this person	☐ Male ☐ Female	☐ Male ☐ Female
Age of this person	☐ Less than 21yrs ☐ 22-29yrs ☐ 30-39yrs ☐ 40-49yrs ☐ 50-59yrs ☐ 60+yrs	☐ Less than 21yrs ☐ 22-29yrs ☐ 30-39yrs ☐ 40-49yrs ☐ 50-59yrs ☐ 60+yrs

What best describes this person's usual activities? Please ✓ ONE BOX only	☐ Works full-time ☐ Works part-time ☐ Unemployed ☐ Retired ☐ Student ☐ Housewife/husband ☐ Other (please describe)	☐ Works full-time ☐ Works part-time ☐ Unemployed ☐ Retired ☐ Student ☐ Housewife/husband ☐ Other (please describe)

Part 7. Travel

7.1 **In the THIRD and FOURTH WEEKS after the accident, did you spend any money on travelling to the A&E department or Minor Injuries Unit or Walk-In Centre because of your child's accident?** *(please ✓ one box)*

☐ Yes ☐ No

If YES, please give details below.

USED PRIVATE CAR

☐ Yes Number of miles for round trip ..... miles Cost of Parking ……

USED PUBLIC TRANSPORT/TAXI

☐ Yes Return fare (£) .....

7.2 **In the THIRD and FOURTH WEEKS after the accident, did you spend any money on travelling to the hospital (other than to the A&E department or Minor Injuries Unit or Walk-In Centre) because of your child's accident?** *(please ✓ one box)*

☐ Yes ☐ No

If YES, please give details below.

USED PRIVATE CAR

☐ Yes Number of miles for round trip ..... miles Cost of Parking ……

USED PUBLIC TRANSPORT/TAXI

☐ Yes Return fare (£) **.....**

7.3 **In the THIRD and FOURTH WEEKS after the accident, did you spend any money on travelling to the GP's surgery because of your child's accident?** *(please ✓ one box)*

☐ Yes ☐ No

If YES, please give details below.

USED PRIVATE CAR

☐ Yes Number of miles for round trip ..... miles Cost of Parking ……

USED PUBLIC TRANSPORT/TAXI

☐ Yes Return fare (£) **.....**

7.4 **In the THIRD and FOURTH WEEKS after the accident, did you spend any money travelling anywhere else because of your child's accident?** *(please ✓ one box)*

☐ Yes ☐ No

If YES, please tell us where you travelled to and give details below.

Travelled to _____

USED PRIVATE CAR

☐ Yes Number of miles for round trip ..... miles Cost of Parking ……

USED PUBLIC TRANSPORT/TAXI

☐ Yes Return fare (£) **.....**

Part 8. Other accidents

Most children have accidents at some time. How well they get better may be affected by having other accidents afterwards. This is why we are asking you about any other accidents your child has had recently.

8.1 **Has your child visited the A&E department or Minor Injuries Unit or Walk-In Centre because of an accident in the THIRD and FOURTH WEEKS after the accident?**

☐ Yes ☐ No

If **YES,** please tick why they went to A&E or Minor Injuries Unit or Walk-In Centre
(Please ✓ all that apply)

☐ A slip, trip, fall or tumble on stairs or steps

☐ A slip, trip, fall or tumble on the same level

☐ A slip, trip, fall or tumble from furniture

☐ Swallowing medicine or pills

☐ Swallowing cleaning products or garden chemicals

☐ A scald from hot water, other hot liquid or steam

☐ Other accident (*Please describe*)……

What sort of accident was it? *(Please ✓ all that apply)*

☐ Loss of consciousness

☐ Bang on the head

☐ Broken bone

☐ Burn or scald

☐ Swallowed household cleaner/other poison/pills

☐ Cut needing stitches

☐ Cut or graze

☐ Other accident

Part 9. General Health

How is your child's health TODAY? Please put an "X" on the line below to indicate how good or how bad your child's health is:

Worst possible health — Perfect health

Part 10. Quality of life (PedsQL™)

PLEASE COMPLETE PART 10 IF YOUR CHILD IS AGED 2 YEARS OR OVER

FOR CHILDREN AGED UNDER 2 YEARS – PLEASE GO TO PART 11

Directions

On the following page is a list of things that might be a problem for your child.
Please tell us how much of a problem each one has been for your child during the **THIRD and FOURTH WEEKS** after the accident:

0 if it is **never** a problem
1 if it is **almost never** a problem
2 if it is **sometimes** a problem
3 if it is **often** a problem
4 if it is **almost always** a problem

There are no right or wrong answers.

In the THIRD and FOURTH WEEKS after the accident, how much of a problem has your child had with…

Physical Functioning (problems with…)	Never	Almost Never	Some-times	Often	Almost Always
1. Walking	0	1	2	3	4
2. Running	0	1	2	3	4
3. Participating in active play or exercise	0	1	2	3	4
4. Lifting something heavy	0	1	2	3	4
5. Bathing	0	1	2	3	4
6. Helping to pick up his or her toys	0	1	2	3	4
7. Having hurts or aches	0	1	2	3	4
8. Low energy level	0	1	2	3	4

Social Functioning (problems with…)	Never	Almost Never	Some-times	Often	Almost Always
1. Playing with other children	0	1	2	3	4
2. Other kids not wanting to play with him or her	0	1	2	3	4
3. Getting teased by other children	0	1	2	3	4
4. Not able to do things that other children his or her age can do	0	1	2	3	4
5. Keeping up when playing with other children	0	1	2	3	4
Emotional Functioning (problems with…)	**Never**	**Almost Never**	**Some-times**	**Often**	**Almost Always**
1. Feeling afraid or scared	0	1	2	3	4
2. Feeling sad or blue	0	1	2	3	4
3. Feeling angry	0	1	2	3	4
4. Trouble sleeping	0	1	2	3	4
5. Worrying	0	1	2	3	4

10.1 **Does your child attend school or day care?** *(please ✓ one box)*

☐ Yes ☐ No

If **YES** *Please complete the next 3 questions*
If **No** *Please go to Part 11*

In the THIRD and FOURTH WEEKS after the accident, how much of a problem has your child had with…

School Functioning (problems with…)	Never	Almost Never	Some-times	Often	Almost Always
1. Doing the same school activities as peers	0	1	2	3	4
2. Missing school/day care because of not feeling well	0	1	2	3	4
3. Missing school/daycare to go to the Doctor or hospital	0	1	2	3	4

Part 11. Your Child

11.1 **Do you think your child is now completely better and their accident is not affecting them anymore?** *(Please ✓ one box)*

☐ Yes ☐ No

Part 12. Any Other Comments

12.1 Please tell us the date you filled in this questionnaire: ……./……./…….

12.2 Are there any other costs that you have had to pay because of your child's accident and you have not been asked about them in this questionnaire? If YES, please tell us about them below:

12.3 Is there anything else you would like to tell us about your child's accident? If YES, please tell us below:

Thank you for taking the time to fill in this questionnaire. Please send it back in the FREEPOST envelope.


keeping Children
SAFE AT HOME