

Appendix 4: Patient status and demographics form

Pt STATUS AND DEMOGRAPHICS Form
 Pre/Post Opioid Clinical Trial (G. Rocker).....

Study PID Number: ____ -- ____ -- ____
 Site # Sequence#

Patient Initials: _____ -- _____ -- _____ First Middle Last
Date of Birth: _____ -- _____ -- _____ Year Month Day
Gender (circle one): F or M

Marital status of Patient:		(√) one
1	Married or living as married	
2	Widowed	
3	Never married	
4	Divorced or separated	
5	Other (specify):	

Oxygen therapy: No _____ Yes _____ Flowrate _____ Saturation _____% FEV1 _____
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Ethnic/ Racial Group – self assessed		(√) one
1	Asian/ Pacific Islander	
2	African/ Black North American	
3	Caucasian	
4	East Indian	
5	Native Canadian	
6	Other (specify);	

Education -- highest level achieved		(√) one
1	Elementary school or less	
2	Some high school	
3	High school graduate	
4	Some college (including CEGEP)/ trade school	
5	College diploma (including DEC)/ trade school	
6	Attended university	
7	University degree	
8	Post graduate degree	
9	Other (specify):	

Employment Status		Has your employment status changed as a result of your illness? <input type="checkbox"/> No or <input type="checkbox"/> Yes – complete below:			
<u>Current</u> Employment Status		(√) one	If YES: What was your <u>previous</u> employment status?		
1	Employed full time		1	Employed full time	
2	Employed part time		2	Employed part time	
3	On paid leave		3	On paid leave	
4	On unpaid leave		4	On unpaid leave	
5	Self-employed		5	Self-employed	
6	Retired		6	Retired	
7	Not employed		7	Not employed	
8	Other (specify):		8	Other (specify):	

0	None	Comorbid Illnesses – circle all number codes that apply			
	Myocardial				Cancer/ Immune
1	Angina		Endocrine	25	Any tumour
2	Arrhythmia	15	Diabetes Type 1 or II	26	Lymphoma
3	Valvular disease	16	Diabetes with end organ damage	27	Leukemia
4	Myocardial infarction			28	AIDS
5	CHF or heart disease	17	Obesity and/ or BMI >30 (weight in kg/ ht in metres) ²	29	Metastatic solid tumour
	Vascular				Psychological
6	Hypertension		Renal	30	Anxiety or panic disorder
7	Peripheral vascular disease or claudication	18	Moderate or severe renal disease	31	Depression
8	Cerebrovascular disease		Gastrointestinal		Muskoskeletal
	Pulmonary	19	Mild liver disease	32	Arthritis (rheumatoid or osteo-)
9	COPD, emphysema			33	Denegerative disc disease (back, spinal stenosis, severe chronic back pain)
10	Asthma	20	Moderate/ severe liver disease	34	Osteoporosis
	Neurologic			35	Connective tissue disease
11	Dementia	21	GI bleeding		Miscellaneous
12	Hemiplegia (paraplegia)	22	Inflammatory bowel disease	36	Visual impairment (cataracts, glaucoma, macular degeneration)
13	Stroke or TIA	23	Peptic ulcer disease	37	Hearing impairment (very hard of hearing even with hearing aid)
14	Neurologic illnesses (e.g. MS or Parkinsons)	24	GI disease (hernia, reflux)		

Palliative Performance Scale (PPS) – Please circle the applicable % level in the far left column					
%	Ambulation	Activity and Evidence of Disease	Self Care	Intake	Consciousness Level
100	Full	Normal Activity No Evidence of Disease	Full	Normal	Full
90	Full	Normal Activity Some Evidence of Disease	Full	Normal	Full
80	Full	Normal Activity with Effort Some Evidence of Disease	Full	Normal or Reduced	Full
70	Reduced	Unable Normal Job/Work Some Evidence of Disease	Full	Normal or Reduced	Full
60	Reduced	Unable Hobby/House Work Significant Disease	Occasional Assistance Necessary	Normal or Reduced	Full or Confusion
50	Mainly Sit/Lie	Unable to Do Any Work Extensive Disease	Considerable Assistance Required	Normal or Reduced	Full or Confusion
40	Mainly in Bed	As Above	Mainly Assistance	Normal or Reduced	Full or Drowsy or Confusion
30	Totally Bed Bound	As Above	Total Care	Reduced	Full or Drowsy or Confusion
20	As above	As Above	Total Care	Minimal Sips	Full or Drowsy or Confusion
10	As above	As Above	Total Care	Mouth Care Only	Drowsy or Coma
0	Death	-	-	-	-

Please continue on next page ----->

Questions about living arrangements:

- a) Tell us about the community in which you live?
 Mostly Rural Mostly Urban Mixed
- b) Does your home have more than one level, i.e., flights of stairs?
 No Yes - if yes, how many? _____
- c) Are you able to drive yourself to medical appointments?
 Yes No longer drive, rely on _____ No vehicle
- d) Do you have children?
 No Yes - number of children _____
- e) Would you say you are a follower of a particular religious tradition? e.g., Christianity, Judaism, Islam, etc.
 No Yes _____ If Christian, denomination _____
- f) How important are these beliefs to you at this point in your life?
 Unimportant Somewhat unimportant neither important nor unimportant Somewhat important Important
- g) Do you have an advance directive (living will or power of attorney for health care decisions)?
 No Don't know Yes: advance directive ____; power of attorney ____
- h) If you were given the choice, where would you prefer to die (for example: at home, in hospital, elsewhere)?
 Don't know at home in hospital elsewhere (please specify) _____

For coordinator/interviewer:

Qualitative interview completed: No _____ Yes _____ date: _____

Completed scales/questionnaires:

VAS..... <input type="checkbox"/>	Global "helpfulness" questions..... <input type="checkbox"/>
QoL..... <input type="checkbox"/>	HADS..... <input type="checkbox"/>
CRQ..... <input type="checkbox"/>	NOSE..... <input type="checkbox"/>

Sign and date this form

Name of Site Research Coordinator/Interviewer: _____

Signature: _____ Date Completed: _____
Year Month Day