What is the clinical effect and cost effectiveness of treating upper limb spasticity due to stroke with botulinum toxin?

Study/EudraCT Number: 2004-002427-40 CTA Number: 01511/0266/001-0001

ONE MONTH ASSESSMENT QUESTIONNAIRE

Version 4: 20 July 2006

Patient Initials:	
Patient Number:	

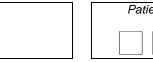
Thank you for completing this questionnaire.

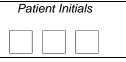
Please can you bring it with you when you come to your one month appointment

Study 2004-002427-40 Patient Number	Patient Initials One Month Questionnaire						
How to answer the questions							
Thank you for filling in this questionnaire. It	may help to complete the questionnaire in						
several stages. All of your answers will be t	reated as confidential. Please try to answer						
every question even if you do not think it ap	olies to you, or if it seems repetitive.						
There are several types of questions in this	booklet. Most of them can be answered by						
ticking a box ✓ for either YES or NO.							
For example:							
Do you live in North Tyneside?							
YES 🗸							
NO							
Compared these guestions have several hove							
Some of these questions have several boxe tick as many boxes as apply to you.	s and you may be asked to tick one only, or						
tion as many boxes as apply to you.							
For example:							
Which vegetables do you like?							
(please tick all boxes that apply)							
Carrots							
Spinach	\checkmark						
Brussel sprouts							
Cabbage	\checkmark						

¹ Month Questionnaire v4: 20 July 2006 (accompanies version 5, 6, 7, 8 and 9 of the protocol)

	Patient Number		
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One Month Questionnaire

A small number of questions ask you to write in your answer on a line.

For example:

In what area of North Tyneside do you live?

I live in Whitley Bay

If you need help with the questions, please ask a friend or relative to assist you.

If you are unsure how to answer any of the questions, please contact us on the telephone number below.

If you find a question too difficult to answer or if you do not wish to answer it, please move on to the next question.

If you have any queries or concerns, please contact:

Joseph Hoben
Project Secretary
School of Population & Health Sciences
University of Newcastle
The Medical School
NE2 4HH

Tel: 0191 222 6779

	Patient Number		Patient Initials	
Study 2004-002427-40				One Month Questionnaire

PART FIVE - Health & Social Services

The questions in this section ask about the services you may have received within the last ONE month. All of the questions may not apply to you but please try to answer every question.

1. Rehabilitation

Within the last ONE month, have you seen any of the following people?

Person	No	Yes As an inpatient	Yes As an outpatient
a. Physiotherapist – Research study			•
b. Physiotherapist - Other			
c. Occupational Therapist			
d. Speech and Language Therapist			
e. Dietician			
f. Chiropodist			
g. Social worker			
h. Clinical psychologist			
i. Other (eg. Doctor or Consultant)			

¹ Month Questionnaire v4: 20 July 2006 (accompanies version 5 of the protocol)

2004-002427-40		Questionnair
2. Have you received treatment from table below within the last ONE	-	the services listed below in the
No Yes		
If Yes, how many times in the last ON	NE month	?
Service	Yes	How many times in the last ONE month?
a. Stroke discharge team/community stroke team		
b. Community rehabilitation team		
c. Day hospital		
3. Have you received any of the following last ONE month?	ollowing s	ervices listed below within the
No Yes		
If Yes, how many times in the last ON	NE month	?
Service	Yes	How many times in the last ONE month?
a. Home care		
b. Private home help		
c. Day centre		
d. Meals on Wheels		
e. Laundry service		

Patient Initials

One Month

Patient Number

Study

f. Respite care

g. Other

¹ Month Questionnaire v4: 20 July 2006 (accompanies version 5, 6, 7, 8 and 9 of the protocol)

4. Have you seen any of the followi ONE month?	ng people	listed below within the last
No Yes		
If Yes, how many times in the last ONI	E month?	
Person	YES	How many times in the last ONE month?
a. General practitioner		
b. Practice nurse		
c. District nurse		
d. Health visitor		
e. Physiotherapist – Research study		
f. Physiotherapist - Other		
g. Occupational therapist		
h. Speech and language therapist		
i. Dietician		
j. Chiropodist		
k. Social worker		
I. Clinical psychologist		

Patient Initials

One Month Questionnaire

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m. Bath attendant

o. Other

n. Continence adviser

¹ Month Questionnaire v4: 20 July 2006 (accompanies version 5, 6, 7, 8 and 9 of the protocol)

	Study 002427-40 One Month Questionnair
5.	Have you been to outpatients other than to attend the upper limb therapy programme in the last ONE month?
	No Yes
	If YES, please can you write down the name of the hospital where you attended outpatients and if possible the name of the department or consultant.
	Outpatient appointment 1
	Name of hospital
	Name of department or consultant
	Reason for appointment
	Outpatient appointment 2
	Name of hospital
	Name of department or consultant
	Reason for appointment
6.	Have you been admitted to and/or discharged from hospital within the last ONE month?
	No Yes
	If YES, please can you give date of admission and date of discharge
	Date of admission
	Reason for admission
	Name of hospital
	Name of department or consultant
	Date of discharge

Patient Initials

Patient Number

¹ Month Questionnaire v4: 20 July 2006 (accompanies version 5, 6, 7, 8 and 9 of the protocol)

Q	Patient Number	Patient Initials	
Study 2004-002427-40			One Month Questionnaire

PART SIX - Aids and Adaptations

The questions in this section ask about your home and any aids and adaptations you may have. If you currently are living in a residential or nursing home, please omit this section. Thank you for completing this questionnaire.

1.	,		rations been made in the example, rails or a bath
	No 🗌	Yes (or waiting for)	

If YES, did you have the alteration/aid to help with bathing before your stroke, after your stroke, or are you waiting for the alteration/aid?

Alteration/aid	Provided before stroke	Provided after stroke	Waiting for
a. Bath or grab rails			
b. Shower			
c. Bath hoist			
d. Bath seat/board			
e. Other - specify			

Study 2004-002427-40	nber	Patient Initials		Month ionnaire
2. Do you have any aids commode, a raised to	-	• .	ole, a	
No Yes	(or waiting for)			
If YES, did you have the air stroke, or are you waiting for		-	stroke, afte	r your
Alteration/aid	Provided before stroke	Provided after stroke	Waiting for	
a. Grab rails				
b. Commode				
c. Bedpan/urinal/bottle				
d. Catheter				
e. Raised toilet seat				
f. Incontinence pads				
e. Other - specify				
3. Do you have any aids get in and out of bed special bed?)		•	_	ı to
No Yes	(or waiting for)			
If YES, did you have the air stroke or are you waiting for		efore your strok	ke, after you	ır
Aid	Provided before	Provided	Waiting	
a. Bed hoist	stroke	after stroke	for	
b. Bed raise/Bed blocks				
c. Special bed/mattress				

d. Other - specify

¹ Month Questionnaire v4: 20 July 2006 (accompanies version 5, 6, 7, 8 and 9 of the protocol)

	Pation (1997) (1	ent Number			Patient Initials		One Mona Questionna		
4. Do you have any of the following aids for your chair or your bed? (For example, special cushions to prevent pressure sores?)									
	No 🗌	Yes (c	r wait	ing for)					
If YES, did you have the aid before your stroke, after your stroke or are you waiting for the item?									
Aid			b	ovided before stroke	Provided after stroke	Waiting for			
a. SI	heepskin								
b. S	pecial cushions								
c. Sp	oecial chair/Chair	raise							
d. O	ther - specify								
5.	5. Have any alterations been made to the house to make things easier for you to get around? No Yes (or waiting for)								
If YES, did you have the alteration made before your stroke, after your stroke or are you waiting for the alteration?									
	Alteration			ovided re stroke	Provided after stroke	Waiti	ng for		
a. W	idened doorways	6							
b. St	tair rails								
c. Stair lift/Vertical lift									
d. Ramp at front or rear									
e. O	ther - specify								

¹ Month Questionnaire v4: 20 July 2006 (accompanies version 5, 6, 7, 8 and 9 of the protocol)

Study 2004-002427-40		Patient Initials	One Month Questionnaire					
6. Do you use any aids for getting about? (For example, a wheelchair or sticks?)								
No Yes (or waiting for)								
If YES, did you have the aid before your stroke, after your stroke or are you waiting for the item?								
Aid	Provided Provided Value Stroke		Waiting for					
a. Manual wheelchair								
b. Electric wheelchair								
c. Walking frame (Zimmer)								
d. Walking stick(s)								
e. Walking trolley								
f. Crutches								
e. Other - specify								
7. Do you have any aids for helping you with meals? (For example, kitchen gadgets or special cutlery?) No Yes (or waiting for)								
If YES, did you have the aid before your stroke, after your stroke or are you waiting for the item?								
Aid	Provided	Provided	Waiting					
a. Kitchen gadgets	before stroke	after stroke	for					
b. Special cutlery/crockery								
c. Feeding tubes								
d. Other - specify								

Thank you for completing this questionnaire. Please see front page for returning instructions.

¹ Month Questionnaire v4: 20 July 2006 (accompanies version 5, 6, 7, 8 and 9 of the protocol)