HEALTHCARE SERVICE UTILISATION FORM

Date: ☐☐ ☐☐ ☐☐ **Assessment Number:** ☐☐

Question 1.

What drugs are prescribed for the patient?

Please list all drugs that the patient has been prescribed in the last 4 months and the quantity that they were prescribed.

No.	Drug	Dose	Quantity (Number of tablets)
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			

Question 2.

In the last 4 months has the patient had a referral to any of the following?

Provider		Number of Visits
Physiotherapy		
Occupational therapy		
Chiropody		
Other, Please State		

Trial Number: ☐ ☐ ☐ ☐ ☐

Question 3.

In the past 4 months has the patient had any of the following laboratory tests.

Type of Test	Number of tests	Where Taken (GP surgery, home hospital)
Blood tests		
Urine tests		

Question 4.

In the past 4 months has the patient made any visits to the hospital outpatient rheumatology department?

Day	Month	Year	Scheduled		Initiated by GP		Initiated by patient	
			Yes	No	Yes	No	Yes	No
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Question 5.

Has the patient made any other outpatient visits to any other hospital department in the last 4 months?

No.	Hospital	Date	Department
1			
2			
3			
4			
5			
6			
7			
8			

Question 6.

Has the patient been admitted by the rheumatology department for an in-patient stay in the last 4 months?

No.	Date Admitted	Date Discharged	In-patient days.
1			
2			
3			
4			
5			

Question 7.

Has the patient been admitted for an in-patient stay for orthopaedic surgery in the last 4 months?

No.	Date Admitted	Date Discharged	In-patient days.
1			
2			
3			
4			
5			

Question 8.

Has the patient had any in-patient stays in the last 4 months apart from those included in question six and question seven?

No.	Date Admitted	Date Discharged	Hospital	Department	In-Patient Days
1					
2					
3					
4					
5					

Services to aid day to day living.

Question 9.

Has the patient had any appliances, aids or house modifications in the last 12 months?

No	Type	Y/N	Date	Quantity	Cost to patient
1	Special Shoes				
2	Special Clothing				
3	Mobility Aids				
4	Special Chair				
5	Special Crockery				
6	Special Cutlery				
7	Special utensils				
8	Tap-Turner				
9	Special Door Handles				
10	Dressing Aids				
11	Hand Splints				
12	Walking Stick				
13	Raised Toilet Seat.				
14	Bath Rails				
15	Adaptations to pens/utensils				
16	Kitchen adaptation				
Other 1					
Other 2					
Other 3					
Other 3					
Other 5					

Question 10.

Does the patient have anybody who comes to their home to help with housework or other domestic chores?

YES/NO

If yes, how many hours a week do they spend in the patients home?_____