Patient screening number S ☐☐☐☐☐ ☐☐☐
Patient initials __ __ __ __

SYCAMORE CSRI Questionnaire

Resource Use Assessments

	Service Provider **<u>Number</u> of contacts in last 3 months (prior to the start of randomised treatment)**								Tick if Not Applicable
	GP	Nurse	Rheumatologist	Ophthalmologist	Other consultant	Optometrist	Psychologist	Other (please specify)	
GP practice									
Telephone calls									
Emails									
Home visits									
Outpatient visits									
A&E visits									
SMS (Text)									
Additional visits (specify)									

Please list any visual aids or other appliances that were supplied in the last 3 months;

Patient screening number S ☐☐☐☐☐ ☐☐☐
Patient initials __ __ __ __

Resource use assessments
Day hospital or in-patient treatment and general questions

*Has the participant been in hospital as a day patient or stayed in the hospital (overnight) during the past 3 months? Yes ☐ No ☐
If yes, give details of the ward and total number of nights.

	Ward speciality [a]	Day case, please tick	Overnight stay (number of nights)	Reason for admission/referral
Visit 1				
Visit 2				
Visit 3				
Visit 4				
Visit 5				
Visit 6				
Visit 7				
Visit 8				
Visit 9				
Visit 10				

[a] Ward speciality code list
1= General Ward 2= Surgical Ward 3= Medical Ward 4= Critical Care 88= Others (Specify)

Is the participant a full time student? Yes ☐ No ☐

Has the participant been off from school, college or work because of the sickness in the last 3 months? Yes ☐ No ☐ N/A ☐

If yes, please state number of days absent from school, college, or work because of the sickness in the last 3 months ☐ N/A ☐