3 Month Questionnaire

DRAFFT
Distal Radius Acute Fracture Fixation Trial

Centre ID: ☐☐☐

Participant ID: ☐☐☐

Date Completed: ☐☐ ☐☐ ☐☐☐☐
(dd/mm/yyyy)

INSTRUCTIONS

Please read these instructions before completing the questionnaire.

Please **do not** sign this form or add your name.

Please follow the instructions for each section carefully.

Please answer ALL the questions. Although it may seem that the questions are asked more than once, it is still important that you answer every one.

Please use a **BLACK** or **BLUE** pen. Please do not use a pencil.

Please check that you have completed all sections.

Please write any notes you have for us on the back page.

For each section, if you are asked to circle a number, please only circle ONE. For example in the following question, if your answer to the question is never, you should place a circle around 0.

Example

Do you suffer from migraines? Never (0) Rarely (1) Occasionally (2) Frequently (3)

If you are asked to put a cross in the box, please use a cross rather than a tick. For example in the following question, if your answer to the question is yes, you should place a cross firmly in the box next to yes.

Example

Do you drive a car? Yes [X] No [ ]

PTO >>>

Section 1—Patient Rated Wrist Evaluation

The following questions below will help us understand how much difficulty you have had with your wrist in the past week. You will be describing the average wrist symptoms over this week on a scale of 0-10.

Please provide an answer for ALL questions. If you did not perform an activity, please ESTIMATE the pain or difficulty you would expect.

1. PAIN

Rate the average amount of pain in your wrist over the past week by circling the number that best describes your pain on a scale from 0-10. A zero (0) means you did not have any pain and a ten (10) means that you had the worst pain you have ever experienced or that you could not do the activity because of pain.

	No pain										Worst ever
At rest	0	1	2	3	4	5	6	7	8	9	10
When doing a task with a repeated wrist movement	0	1	2	3	4	5	6	7	8	9	10
When lifting a heavy object	0	1	2	3	4	5	6	7	8	9	10
When it is at its worst	0	1	2	3	4	5	6	7	8	9	10

	Never										Always
How often do you have pain?	0	1	2	3	4	5	6	7	8	9	10

2. FUNCTION

A. Specific Activities

Rate the amount of difficulty you experienced performing each of the items listed below – over the past week, by circling the number that describes your difficulty on a scale of 0-10. A zero (0) means you did not experience any difficulty and a ten (10) means it was so difficult you were unable to do it at all.

	No difficulty										Unable to do
Cut meat using a knife in my affected hand	0	1	2	3	4	5	6	7	8	9	10
Turn a door knob using my affected hand	0	1	2	3	4	5	6	7	8	9	10
Use my affected hand to push up from a chair	0	1	2	3	4	5	6	7	8	9	10
Fasten buttons on my shirt	0	1	2	3	4	5	6	7	8	9	10

	No difficulty										Unable to do
Carry a 10lb object in my affected hand	0	1	2	3	4	5	6	7	8	9	10
Use a bathroom tissue with my affected hand	0	1	2	3	4	5	6	7	8	9	10

B. Usual Activities

Rate the amount of difficulty you experienced performing your usual activities in each of the areas listed below, over the past week, by circling the number that best describes your difficulty on a scale of 0-10. A zero (0) means that you did not experience any difficulty and a ten (10) means it was so difficult you were unable to do any of your usual activities.

	No difficulty										Unable to do
Personal care activities (dressing, washing)	0	1	2	3	4	5	6	7	8	9	10
Household work (cleaning, maintenance)	0	1	2	3	4	5	6	7	8	9	10
Work (your job or usual everyday work)	0	1	2	3	4	5	6	7	8	9	10
Recreational activities	0	1	2	3	4	5	6	7	8	9	10

Section 2—Disabilities of the Arm, Shoulder and Hand

These questions ask about your symptoms and ability to perform certain activities.

Please answer **ALL** questions, based on your condition in the last week , by circling the appropriate number.

If you did not have the opportunity to perform an activity in the past week, please make your best estimate on which response would be the most accurate.

It doesn't matter which hand you use to perform the activity, please answer based on your ability regardless of how you perform the task.

	No Difficulty	Mild Difficulty	Moderate Difficulty	Severe Difficulty	Unable
1. Open a tight new jar	1	2	3	4	5
2. Write	1	2	3	4	5
3. Turn a key	1	2	3	4	5
4. Prepare a meal	1	2	3	4	5

		No Difficulty	Mild Difficulty	Moderate Difficulty	Severe Difficulty	Unable
5.	Push open a heavy door	1	2	3	4	5
6.	Place an object on a shelf above your head	1	2	3	4	5
7.	Do heavy household chores (e.g., wash walls, wash floors)	1	2	3	4	5
8.	Garden or do yard work	1	2	3	4	5
9.	Make a bed	1	2	3	4	5
10.	Carry a shopping basket or briefcase	1	2	3	4	5
11.	Carry a heavy object (over 10lbs)	1	2	3	4	5
12.	Change a light bulb overhead	1	2	3	4	5
13.	Wash or blow dry your hair	1	2	3	4	5
14.	Wash your back	1	2	3	4	5
15.	Put on a pullover sweater	1	2	3	4	5
16.	Use a knife to cut food	1	2	3	4	5
17.	Recreational activities which require little effort (e.g., cardplaying, knitting etc)	1	2	3	4	5
18.	Recreational activities in which you take some force or impact through your hand (e.g. golf, hammering, tennis)	1	2	3	4	5
19.	Recreational activities in which you move your arm freely (e.g. playing Frisbee, badminton etc)	1	2	3	4	5
20.	Manage transportation needs (getting from one place to another)	1	2	3	4	5
21.	Sexual activities	1	2	3	4	5

		Not at all	Slightly	Moderately	Quite a bit	Extremely
22.	During the past week to what extent has your arm, shoulder or hand problem interfered with your normal social activities with family, friends, neighbours or groups?	1	2	3	4	5

		Not limited at all	Slightly limited	Moderately limited	Very limited	Unable
23.	During the past week, were you limited in your work or other regular daily activities as a result of your arm, shoulder or hand problem	1	2	3	4	5

Please rate the severity of the following symptoms in the last week

		None	Mild	Moderate	Severe	Extreme
24.	Arm, shoulder or hand pain	1	2	3	4	5
25.	Arm, shoulder or hand pain when you performed any specific activity	1	2	3	4	5
26.	Tingling (pins and needles) in your arm, shoulder or hand.	1	2	3	4	5
27.	Weakness in your arm, shoulder or hand.	1	2	3	4	5
28.	Stiffness in your arm, shoulder or hand.	1	2	3	4	5

		No difficulty	Mild difficulty	Moderate difficulty	Severe difficulty	So much difficulty that I can't sleep
29.	During the past week, how much difficulty have you had sleeping because of pain in your arm, shoulder or hand?	1	2	3	4	5

		Strongly Disagree	Disagree	Neither agree nor disagree	Agree	Strongly Agree
30.	I feel less capable, less confident or less useful because of my arm, shoulder or hand problem	1	2	3	4	5

Section 3—Quality of Life

These questions refer to your general health. By placing a cross in ONE box in each group, please indicate which statement best describes your own health state today.

1. **Mobility:**

- I have no problems in walking about ☐
- I have some problems in walking about ☐
- I am confined to bed ☐

2. **Self-Care:**

- I have no problems with self-care ☐
- I have some problems washing or dressing myself ☐
- I am unable to wash or dress myself ☐

3. **Usual activities (e.g. work, study, housework, family or leisure activities)**

- I have no problems with performing my usual activities ☐
- I have some problems with performing my usual activities ☐
- I am unable to perform my usual activities ☐

4. **Pain/Discomfort**

- I have no pain or discomfort ☐
- I have moderate pain or discomfort ☐
- I have extreme pain or discomfort ☐

5. **Anxiety/Depression**

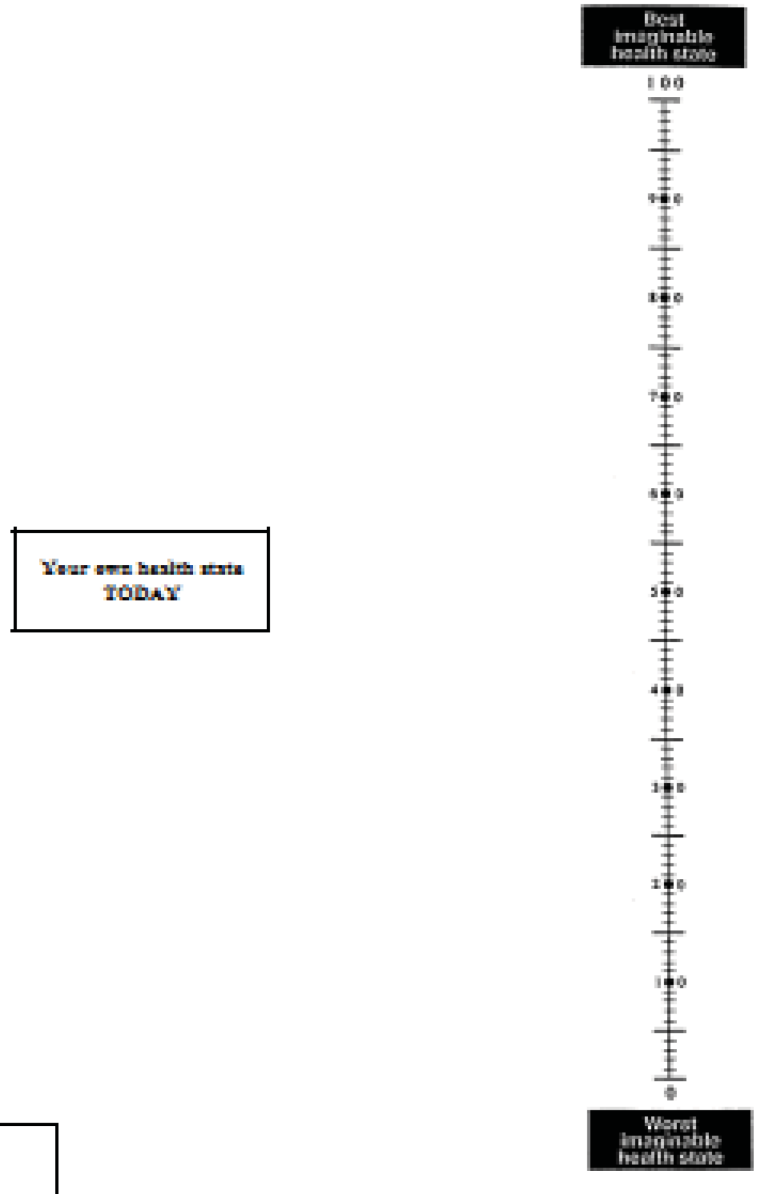
- I am not anxious or depressed ☐
- I am moderately anxious or depressed ☐
- I am extremely anxious or depressed ☐

Your own health state TODAY.

To help people say how good or bad a health state is, we have drawn a scale (rather like a thermometer) on which the best state you can imagine is marked 100 and the worst you can imagine is marked 0.

We would like you to indicate on this scale how good or bad your own health is TODAY, in your opinion.

Please do this by drawing a line from the box below, to whichever point on the scale indicates how good or bad your current health state is.



Office use only:

Section 4

1. Other support from government benefits

Are you receiving any of the below Yes ☐ No ☐

If No, go to question 2

If Yes, can you please tick all benefits you have received in the past 3 months and how much you currently receive in benefits each week.

Can you please estimate how much you receive altogether in benefits per week? £.....

Attendance Allowance	☐	Income Support	☐
Carer's Allowance	☐	Jobseeker's Allowance	☐
Child Tax Credit	☐	Pension Credit	☐
Council Tax Benefit	☐	Statutory Sick Pay	☐
Disability Living Allowance—caring	☐	State Pension	☐
Disability Living Allowance—mobility	☐	Other:	☐
Employment and Support Allowance	☐	Other:	☐
Housing Benefit	☐	Other:	☐

2. Where you live

As of today, do you live in:

A residential house, flat or bungalow ☐

Assisted living/retirement village ☐

A care home without 24 hour nursing ☐

A care home with 24 hour nursing available ☐

Section 5

Complications

In the past 3 months have you been treated for any of the following events?

1. Wound complication — Yes ☐ No ☐
2. Further surgery because of your wrist fracture — Yes ☐ No ☐
3. A regional pain syndrome — Yes ☐ No ☐
4. DVT (Deep Vein Thrombosis) — Yes ☐ No ☐
   - If yes, Did you see the DVT nurse — Yes ☐ No ☐
   - Were you prescribed medication — Yes ☐ No ☐
5. Any other complications — Yes ☐ No ☐
   - If yes, please specify .....

Have you had any other unscheduled appointment at hospital because for your wrist fracture — Yes ☐ No ☐

If you are unsure about any of these questions, please cross here ☐ and someone from the research team will get in contact with you to help you answer these questions.

Physiotherapy Exercise

1. Upon discharge from the hospital, did you receive exercise instruction sheets? — Yes ☐ No ☐
2. Were the exercise instruction sheets explained to you — Yes ☐ No ☐
3. Did you perform the exercises as instructed — Yes ☐ No ☐
   - If Yes, how often did you repeat the exercises? .....times/day
   - And for how many days did you repeat these exercises .....days
4. Did you have any additional therapy for your wrist — Yes ☐ No ☐
   - If Yes, who provided this therapy?
     - Physiotherapist ☐
     - Hand therapist ☐
     - Other ☐
   - And how often did you have this therapy? .....

Resource Use

Please think back over the times that you have used the NHS since being discharged. If you are unsure about any answer please write in your best recollection.

1. Inpatient care

Since being discharged following your operation, have you been admitted to hospital again? Yes ☐ No ☐

If you can, please tell us which department of the hospital you went to (speciality) and whether or not you had to stay overnight. If you don't know which speciality it was or if it's not listed, then just write in the reason or part of your body as best you can.

	Did you stay overnight?	Total stay
Orthopaedics (your wrist/arm)	Just the day ☐ Overnight ☐	☐☐☐ Days
Orthopaedics (any other bones)	Just the day ☐ Overnight ☐	☐☐☐ Days
Rehabilitation unit	Just the day ☐ Overnight ☐	☐☐☐ Days
For any other surgery? Details:	Just the day ☐ Overnight ☐	☐☐☐ Days
For any other non-surgical reason? Details:	Just the day ☐ Overnight ☐	☐☐☐ Days

2. Outpatient care

Since being discharged following your operation, have you made any visits to the hospital or a clinic as an outpatient? Yes ☐ No ☐

If you can, please indicate which part of the hospital you went to (speciality). If you don't know which speciality it was, or if it's not listed, then write in the reason or part of your body as best you can.

Speciality	Examples	Number of visits
Orthopaedics	Seeing a surgeon about your wrist fracture, changes to plaster or aids (e.g. splint/braces)	
Pathology	For blood tests	
Radiology	For X-rays	
Physiotherapy (NHS)	Physiotherapy appointment at the hospital to see an NHS physiotherapist	
Physiotherapy (Private)	Physiotherapy appointment to see a private physiotherapist (anywhere)	
Others: Details		
Others: Details		

3. Contacts with other health and social care professionals

In the last three months, have you seen any other professionals in the community because of your wrist fracture?

Yes ☐ No ☐

If you can, please indicate the person you saw, how often you saw them and where this was. If the person isn't listed then feel free to write this in.

	Total number of contacts with NHS and social services staff				Total time spent
	GP Surgery	Clinic (non-hospital)	By Phone	At home	
GPs	☐☐ visits	☐☐ Visits	☐☐ times	☐☐ visits	☐☐ minutes
Practice nurse	☐☐ visits	☐☐ Visits	☐☐ times	☐☐ visits	☐☐ minutes
District nurse	☐☐ visits	☐☐ Visits	☐☐ times	☐☐ visits	☐☐ hours
Physiotherapist	☐☐ visits	☐☐ Visits	☐☐ times	☐☐ visits	☐☐ hours
Occupational therapist	☐☐ visits	☐☐ Visits	☐☐ times	☐☐ visits	☐☐ hours
Other: details					.....
Other: details					.....

4. Medications

In the tables below, please note any medications (including pain relief) that you have been prescribed by a doctor or other health professional in relation to your wrist fracture in the past three months. Please ignore the medications you were provided at your discharge from hospital and anything that you bought without a prescription ("over the counter").

Medications (+ dosage)	Number of times daily	Number of days used

5. Other aids and adaptations

In the **past three months**, the NHS or local social services may have provided some equipment to protect your injury or make your day to day life easier to manage. In the following table, please indicate whether you have received the equipment stated. If an item you have received isn't listed then feel free to write this in.

Aids and adaptation	Used?	Number received
Wrist brace/splint	Yes ☐ No ☐	☐☐☐
Grab rail	Yes ☐ No ☐	☐☐☐
Dressing aids	Yes ☐ No ☐	☐☐☐
Long-handle shoe horns	Yes ☐ No ☐	☐☐☐
Bathing aids	Yes ☐ No ☐	☐☐☐
Kitchen aids (jar/tin openers, special cutlery etc)	Yes ☐ No ☐	☐☐☐
Other	Yes ☐ No ☐	☐☐☐
Other	Yes ☐ No ☐	☐☐☐

6. Other support from personal social services

In the **past three months**, personal social services may provided some other services to make your day to day life easier to manage. In the following table, please indicate whether you have received the service stated, how often you received it, and whether you are still receiving this support. If the type of support you have received isn't listed then feel free to write this in.

Have you used personal social services? Yes ☐ No ☐
If Yes, please give details in the table below

Other support	How many times?	Is help ongoing?
Meals on wheels (frozen, weekly)	☐☐☐ weeks	Yes ☐ No ☐
Meals on wheels (hot, daily)	☐☐☐ weeks	Yes ☐ No ☐
Laundry services	☐☐☐ weeks	Yes ☐ No ☐
Care workers/Help at home	☐☐☐ visits	Yes ☐ No ☐
Social workers	☐☐☐ Visits	Yes ☐ No ☐
Other: Details	.....	Yes ☐ No ☐
Other: Details	.....	Yes ☐ No ☐

7. Time off work

Are you currently working? Yes ☐ No ☐

If No, is this: Because of your wrist fracture ☐ Because of other health reasons ☐
Because you are retired or unable to work for other reasons ☐

In the three months, have you taken **time off work** or **lost any income** because of your wrist fracture? If yes, please provide details below:

Days lost: ..... Income lost: .....

Section 6

1. Compared to when you attended your '6 week' follow up appointment does your wrist feel

Substantially Better ☐
Moderately Better ☐
No Different ☐
Moderately Worse ☐
Substantially Worse ☐

2. How satisfied were you with the treatment you received ?

Extremely Satisfied ☐
Very Satisfied ☐
Somewhat Satisfied ☐
Neither Satisfied nor Dissatisfied ☐
Somewhat Dissatisfied ☐
Very Dissatisfied ☐
Extremely Dissatisfied ☐

3. Have your contact details changed or likely to change in the next three months?

Yes ☐ No ☐

If Yes, please give your new details below:

House/Flat number: .....
Street Name: .....
.....
Town/City: .....
Postcode: .....
Email: .....

Telephone
Home: .....
Work: .....
Mobile: .....
Preferred method/time of contact: .....

That is the end of the questionnaire.

Please check that you have completed all sections.

We will send you another questionnaire in three months. In the meantime, please keep a record of any days off work, hospital or GP visits, medication, use of special equipment or support you may receive as a result of your broken wrist.

Please write any notes you have for us in the space below and return the questionnaire in the reply-paid envelope provided.

Thank you very much for your time.

Notes