STITCH (TRAUMA)

Surgical Trial in Traumatic Intracerebral Haemorrhage

6 Month Postal Follow-up Form

FOR RESEARCH USE ONLY

(Version 2, 30/09/2010: for UK sites)

Patient Number ☐ Centre Number ☐

CONFIDENTIAL

About this questionnaire

It is now **6 months** since your head injury. These questions ask about your general health and the health care and assistance from carers that you have received since your head injury. Please think carefully about each question. Most of the questions can be answered by ticking the box next to the answer that applies to you. Some questions will require you to write a brief response in the space provided.

If you are unsure how to answer any question, please give the best answer you can and write in any comments you wish to make.

Your name and address do not appear anywhere in this leaflet. The information you give us will not be used in any way that could identify you personally.

If you are unable to answer the questions yourself please ask a relative, friend or carer to help you.

Thank you for taking the time to answer these questions.

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First, some details about yourself and where you are living since your head injury six months ago.

1. Your Date of Birth DD / MM / YYYY

☐ / /

2. Your Gender:

Male ☐

Female ☐

3. At present are you living:

*Please tick **one** of the boxes*

At home alone ☐

At home not alone ☐

In a residential home ☐

In a nursing home ☐

In a hospital ☐

4. Have you had to go and live with family or friends because of your head injury?

Yes ☐ No ☐

5. Has anyone had to move in with you?

Yes ☐ No ☐

6. Have you had to move into a residential home, nursing home or hospital because of your head injury?

Yes ☐ No ☐

7. If yes, what date did you move in to the residential home or nursing home?

☐ / /

DD / MM / YYYY

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Glasgow Outcome Scale

We are interested in whether any changes or impairments that have occurred as a result of your head injury have affected aspects of your daily life. Changes are often physical, but sometimes the most important changes which take place after head injury are mental. The main questions concern how well you are doing activities at present, that is over the past week or so. There are also some questions about how things were before the head injury. The questions can be answered by the person with the head injury, or by a relative or close friend, or by both together.

Please answer all the questions

Independence in the Home/Indoors

8. As a result of changes caused by your head injury is assistance at home essential every day for your care?

(Please tick ***one*** of the boxes)

☐ I do not need assistance or supervision at home.

☐ As a result of the head injury I need some assistance but I could look after myself for 24 hours if necessary.

☐ As a result of the head injury I could look after myself for up to 8 hours if necessary, but not for 24 hours.

☐ As a result of the head injury I could not look after myself for 8 hours during the day.

☐ I could not look after myself for some other reason, not because of the head injury.

9. Before the head injury, I was able to care for myself at home:

Yes ☐ No ☐

Independence Outside the Home

10. As a result of changes caused by your head injury are you unable to shop without assistance?
(Please tick ***one*** of the boxes)

☐ I have no difficulty shopping.

☐ As a result of the head injury I have some difficulty shopping, but I could go to local shops without assistance.

☐ As a result of the head injury I am unable to do any shopping without assistance.

☐ I am unable to shop without assistance for some other reason, not because of the head injury.

11. Before the head injury I was able to shop without assistance.

Yes ☐ No ☐

12. As a result of changes caused by your head injury are you unable to travel locally without assistance?

(Please tick ***one*** of the boxes)

☐ I have no difficulty travelling.

☐ As a result of the head injury I have some difficulty travelling, but could travel locally without assistance (eg. by arranging a taxi).

☐ As a result of the head injury I am unable to travel without assistance.

☐ I am unable to travel without assistance for some other reason, not because of the head injury.

13. Before the head injury I was able to travel without assistance.

Yes ☐ No ☐

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Work

14. As a result of changes caused by your head injury has there been an alteration in your capacity to work (or to study if you were a student)?

(Please tick ***one*** of the boxes)

☐ I am able to return to the same work.

☐ As a result of my head injury I can only work at a reduced level (eg., change from full-time to part-time or change the level of responsibility), but I am still able to work.

☐ As a result of my head injury I am unable to work, or only able to work in a sheltered workshop.

☐ My work capacity is affected for some other reason, not because of the head injury.

15. Before the head injury I was working or seeking work (or studying as a student):

Yes ☐ No ☐ Retired ☐

Social and Leisure Activities

16. As a result of changes caused by your head injury have you been unable to resume regular social and leisure activities outside home?

(Please tick ***one*** of the boxes)

☐ I participate about as often as before (the activities may be different from before).

☐ As a result of my head injury I participate a bit less often,but at least half as often as before the head injury.

☐ As a result of my head injury I participate much less, less than half as often as before the head injury.

☐ As a result of my head injury I am unable to participate, and rarely, if ever,take part.

☐ I participate less for some other reason, not because of the head injury.

17. Before the head injury I participated in regular social and leisure activities outside home.

Yes ☐ No ☐

Family and Friendships

18. As a result of psychological changes caused by your head injury is there ongoing disruption to your family or disruption to friendships?

(Please tick ***one*** of the boxes)

☐ Relationships are still much the same as before.

☐ As a result of the head injury there are occasional problems– less than weekly.

☐ As a result of the head injury there are frequent problems– once a week or more.

☐ As a result of the head injury there are constant problems – problems every day.

☐ There are problems for some other reason, not because of the head injury.

19. Before the head injury did you have any problems with relationships?
(Please tick ***one*** of the boxes)

☐ I had no problems before, or minor problems.

☐ I had similar problems before **.**

Any Other Problems with Return to Normal Life

20. Are there any other changes or symptoms resulting from your head injury which interfere with daily life? (Problems sometimes reported after head injury include headaches, dizziness, tiredness, sensitivity to noise or light, slowness, memory failures and concentration problems).
(Please tick ***one*** of the boxes)

☐ I have no current problems.

☐ I have some problems from the head injury, but these do not interfere with my daily life.

☐ I have some problems from the head injury, and these have affected my daily life.

☐ I have some problems for other reasons, not because of the head injury.

21. Before the head injury were similar problems present?

(Please tick ***one*** of the boxes)

☐ I had no problems before.

☐ I had minor problems.

☐ I had similar problems before.

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These questions concern your stay in hospital.

22. What date were you first discharged from hospital after your head injury?

DD / MM / YYYY

☐ / ☐ / ☐

23. Have you been re-admitted to hospital since?

Yes ☐ No ☐

24. **If yes**, please tell us the dates you were back in hospital (please write extra notes/dates in the margin if more than once).

From: DD/MM/YYYY ☐ / ☐ / ☐ To: DD/MM/YYYY ☐ / ☐ / ☐

And please tell us which hospitals you were in: ☐

These questions concern whether the head injury has affected your ability to move your limbs.

25. At present, how has the head injury affected your **left leg**?
(Please tick ***one*** of the boxes)
No problem ☐ Some weakness ☐ Unable to move it ☐

26. At present, how has the head injury affected your **right leg**?
(Please tick ***one*** of the boxes)
No problem ☐ Some weakness ☐ Unable to move it ☐

27. At present, how has the head injury affected your **left arm**?
(Please tick ***one*** of the boxes)
No problem ☐ Some weakness ☐ Unable to move it ☐

28. At present, how has the head injury affected your **right arm**?
(Please tick ***one*** of the boxes)
No problem ☐ Some weakness ☐ Unable to move it ☐

29. At present how has the head injury affected your ability to say words or to choose the words you want?
(Please tick ***one*** of the boxes)
No problem ☐ Some problems ☐ Major problems ☐

30. How has the head injury affected your ability to understand the spoken or written word?
(Please tick ***one*** of the boxes)
No problem ☐ Some problems ☐ Major problems ☐

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31. Do you often feel sad or depressed? Yes ☐ No ☐

32. As a result of your head injury, how would you rate your general health?

(Please tick the ***one*** box which seems most appropriate to you)

- ☐ I am perfectly fit and well.
- ☐ I have a few minor problems but they do not affect my lifestyle.
- ☐ I can do all everyday activities, but my lifestyle is restricted.
- ☐ My lifestyle is very restricted. I need some help with everyday activities.
- ☐ My lifestyle is very restricted. I need a lot of help but not constant attention.
- ☐ I am totally dependent and need 24 hour care.

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EuroQol (at 6 months)

By placing a tick in one box in each group below, please indicate which statements best describe your own health state today.

*Please tick **one** box only for each question*

33. Mobility

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

34. 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 ☐

35. 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 ☐

36. Pain/Discomfort

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

37. Anxiety/Depression

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

These questions ask about your work after your head injury.

38. Are you currently employed?

(*please tick **one** box*)

☐ Yes **(CONTINUE WITH QUESTION 39)**

☐ No **(SKIP QUESTIONS 39-42, AND GO TO QUESTION 43)**

39. During the past seven days, how many hours did you miss from work because of your head injury? (Include hours you missed on sick days, times you went in late, left early, etc. Do not include time you missed to participate in this study).

_____hours

40. During the past seven days, how many hours did you miss from work because of any other reason, such as vacation, holidays, time off to participate in this study?

_____hours

41. During the past seven days, how many hours did you actually work?

_____hours

42. During the past seven days, how did your head injury affect your productivity while you were working? Think about days you were limited in the amount or kind of work you could do, days you accomplished less than you would like, or days you could not do your work as carefully as usual. On a scale of 0 to 10, how has the head injury affected your work? If it has affected your work only a little, choose a low number. Choose a high number if it has affected your work a great deal.

0 1 2 3 4 5 6 7 8 9 10

43. During the past seven days, how much did your head injury affect your ability to do your regular daily activities, other than work at a job? By regular activities, we mean the usual activities you do, such as work around the house, shopping, childcare, exercising, studying, etc. Think about times you were limited in the amount or kind of activities you could do and times you accomplished less than you would like. On a scale of 0 to 10, how has the head injury affected your regular daily activities, other than work at a job? If it has affected your activities only a little, choose a low number. Choose a high number if it has affected your activities a great deal.

0 1 2 3 4 5 6 7 8 9 10

The following two questions (questions 44 and 45) ask about whether you receive any care from partners, other relatives, friends or neighbours now.

44. As a result of your head injury, do you currently receive care or help, from others with any of the following: washing yourself, going to the toilet, eating?

(*please tick **one** box*)

☐ Yes

☐ No

45. As a result of your head injury, do you currently receive care or help, from others, with any of the following: getting dressed, moving around the house, housework, transportation?

(*please tick **one** box*)

☐ Yes

☐ No

PLEASE GO TO THE NEXT PAGE

46. Since your head injury have you experienced any of the following:

i) Epilepsy	Yes	☐	No	☐
ii) Unexplained fits	Yes	☐	No	☐
iii) Persistent headaches	Yes	☐	No	☐
iv) Dizziness	Yes	☐	No	☐
v) Difficulty concentrating	Yes	☐	No	☐

47. Have you been prescribed any anti-epileptic medication since your head injury?

Yes ☐ No ☐

Is there anything else you would like to tell us about how you have been feeling?

(Please use the space below)

.....

.....

.....

.....

These questions concern the contacts you have had with professional carers and therapy providers.

1. Have you visited a **day hospital** since you were first discharged from hospital after your head injury? *A day hospital is a non residential hospital or part of a hospital where patients go for medical treatment or therapy during the daytime.*

Yes ☐ No ☐ **If yes,** how many times? ☐

2. Have you visited a **day centre** since you were first discharged from hospital after your head injury? *A day centre is a non-residential place where people can go for general daytime care or recreation.*

Yes ☐ No ☐ **If yes,** how many times? ☐

3. In the past **month** have you seen any of the following:

a) a **home help**/**professional home carer**?

Yes ☐ No ☐ **If yes,** how many times? ☐

b) a **District Nurse**?

Yes ☐ No ☐ **If yes,** how many times? ☐

c) a **Physiotherapist**?

Yes ☐ No ☐ **If yes,** how many times? ☐

d) an **Occupational Therapist**?

Yes ☐ No ☐ **If yes,** how many times? ☐

e) a **Speech Therapist**?

Yes ☐ No ☐ **If yes,** how many times? ☐

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These questions ask about who completed this questionnaire.

1. This questionnaire was completed on: ☐ / /

DD/MM/YYYY

2. This questionnaire was answered by:

(*please tick **one** box*)

- ☐ Yourself alone
- ☐ A relative/friend/carer
- ☐ Yourself with help from a relative/friend/carer

3. If answered by or with the help of a relative/friend/carer, what is their relationship to you?

(*please tick **one** box*)

- ☐ Husband/Wife/Partner
- ☐ Mother/ Father
- ☐ Sister/Brother
- ☐ Son/Daughter
- ☐ Other relative
- ☐ Friend
- ☐ Professional Carer

4. If a relative/friend/carer has helped you **to complete this form** please indicate **how** they have helped you: (*please tick **all** that apply*)

- ☐ They read out the questions to me
- ☐ They recorded my answers to the questions
- ☐ They answered questions on my behalf

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Thank you for completing this questionnaire.

Your answers will help us improve treatment of head injury patients with intracerebral haemorrhage in future. If there are any queries we may contact you directly.

Please place this questionnaire in the enclosed stamped addressed envelope and return it to:

STITCH (Trauma),
Neurosurgical Trials Unit,
3-4 Claremont Terrace,
Newcastle University,
Newcastle upon Tyne,
NE2 4AE, U.K.