calories

CALORIES: a multicentre, randomised controlled trial comparing the clinical and cost-effectiveness of early nutritional support in critically ill patients via the parenteral versus the enteral route

HEALTH QUESTIONNAIRE

We would be grateful if you would complete this questionnaire. The CALORIES trial aims to improve the care of critically ill patients.

A pen is provided and a FREEPOST envelope for return of the questionnaire. Please answer multiple choice questions by putting a ✓ in ONE BOX for each question.

Please complete today's date below:

____ / ____ / ____

Day Month Year

Please also let us know whether you completed this questionnaire:

- ☐ Alone
- ☐ With help
- ☐ Or it was completed by someone who cares for you

NOW PLEASE TURN THE PAGE TO START THE QUESTIONNAIRE ▶

If you do not wish to complete this questionnaire, please tick the box and return the unanswered questionnaire in the stamped self-addressed envelope provided.

I do not wish to complete this questionnaire ☐

Your current and future care will not be affected whether you decide to, or not to, fill in this questionnaire.

YOUR HEALTH

We would like to understand how your health is since you left the critical care unit.
There are no right or wrong answers. We have found that the best way to answer the questions is to go with your first instinct, whatever **you** think is the correct response for you.

Under each heading, please tick the ONE box that best describes your health TODAY

MOBILITY

I have no problems in walking about ❑
I have slight problems in walking about ❑
I have moderate problems in walking about ❑
I have severe problems in walking about ❑
I am unable to walk about ❑

SELF-CARE

I have no problems washing or dressing myself ❑
I have slight problems washing or dressing myself ❑
I have moderate problems washing or dressing myself ❑
I have severe problems washing or dressing myself ❑
I am unable to wash or dress myself ❑

USUAL ACTIVITIES *(e.g. work, study, housework, family or leisure activities)*

I have no problems doing my usual activities ❑
I have slight problems doing my usual activities ❑
I have moderate problems doing my usual activities ❑
I have severe problems doing my usual activities ❑
I am unable to do my usual activities ❑

PAIN / DISCOMFORT

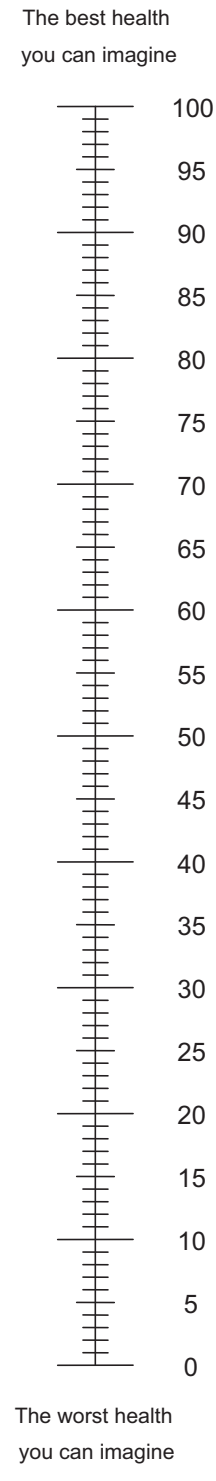
I have no pain or discomfort ❑
I have slight pain or discomfort ❑
I have moderate pain or discomfort ❑
I have severe pain or discomfort ❑
I have extreme pain or discomfort ❑

ANXIETY / DEPRESSION

I am not anxious or depressed ❑
I am slightly anxious or depressed ❑
I am moderately anxious or depressed ❑
I am severely anxious or depressed ❑
I am extremely anxious or depressed ❑

- We would like to know how good or bad your health is TODAY.
- This scale is numbered from 0 to 100.
- 100 means the best health you can imagine.
  0 means the worst health you can imagine.
- Mark an X on the scale to indicate how your health is TODAY.
- Now, please write the number you marked on the scale in the box below.

YOUR HEALTH TODAY = ☐



Please think of all the things you do and experience in relation to food and meals (e.g. planning meals, shopping, preparing meals, eating meals) and then, using the **1** (disagree) – **7** (agree) scale, indicate your agreement with each item below.

	Please score 1 - 7
Food and meals are positive elements in my life	☐
I am generally pleased with my food	☐
Food and meals give me satisfaction in daily life	☐
My life in relation to food and meals is close to my ideal	☐
With regard to food, the conditions of my life are excellent	☐

HEALTH SERVICES

We would be grateful if you would complete this questionnaire. It will help us understand the care you needed after leaving hospital.

The questions refer to ALL health services that you have used since leaving the hospital on <Discharge date>, and before <Three months/one year>.

Part 1. Hospital Stay

A Since you left hospital on <Discharge date> have you stayed overnight in hospital for any reason?

☐ No - Go to Part 2

☐ Yes - Please give details about the number of stays below

B For EACH TIME you stayed in hospital please answer the following

	Number of nights		1-3 nights	4-10 nights	11 or more nights	Did you spend any part of your stay in critical care?
1st Stay	____	or…	☐	☐	☐	☐
2nd Stay	____	or…	☐	☐	☐	☐
3rd Stay	____	or…	☐	☐	☐	☐
4th Stay*	____	or…	☐	☐	☐	☐

**If you have stayed in hospital overnight more than 4 times, please could you provide information on these further hospital stays in Part 6 of the questionnaire.*

Part 2. Hospital outpatient visits

Outpatient visits are when a patient comes to the hospital to see a specialist (e.g. consultant) but does not stay overnight.

A Since you left hospital on <Discharge date> have you visited hospital outpatients about ANY ASPECT of your health?

- ☐ No - Go to Part 3
- ☐ Yes - Please give details about the number of outpatients visit(s) below

B

Number of visits		or…	1-3 visits	4-10 visits	11 or more visits
	_____	or…	☐	☐	☐

Part 3. Visits to health care providers

A Since you left hospital on <Discharge date> have you visited any of the health care providers listed below?

- ☐ No - Go to Part 4
- ☐ Yes - Please give details about your visits below

B For EACH PROVIDER please answer the following

Did you visit this provider?		Number of visits		1-3 visits	4-10 visits	11 or more visits
GP	☐	_____	or…	☐	☐	☐
Nurse at your GP clinic	☐	_____	or…	☐	☐	☐
Nurse at hospital or elsewhere	☐	_____	or…	☐	☐	☐
Health visitor	☐	_____	or…	☐	☐	☐

Part 4. Visits to your home by health care providers

A Since you left hospital on <Discharge date> have you had home visits from any the following health care providers about ANY ASPECT of your health?

☐ No - Go to Part 5

☐ Yes - Please give details about your visits below

B For EACH HOME VISIT please answer the following

Were you visited at home by this provider?		Number of visits		1-3 visits	4-10 visits	11 or more visits
GP	☐	____	or…	☐	☐	☐
Nurse from your GP clinic	☐	____	or…	☐	☐	☐
Occupational Therapist	☐	____	or…	☐	☐	☐
Health visitor or District nurse	☐	____	or…	☐	☐	☐

Part 5. Visits to other service providers

A Since you left hospital on <Discharge date> please indicate whether you have had contact (either visits to the provider or home visits) with any of the following service providers about any aspect of your health?

☐ No - Go to Part 6

☐ Yes - Please give details below

B For EACH PROVIDER please answer the following

Have you had contact with any of these providers?		Number of visits		1-3 visits	4-10 visits	11 or more visits
Occupational therapist	☐	____	or…	☐	☐	☐
Psychologist	☐	____	or…	☐	☐	☐
Speech and Language therapist	☐	____	or…	☐	☐	☐
Physiotherapist	☐	____	or…	☐	☐	☐
Dietician	☐	____	or…	☐	☐	☐

Part 6. Other services not listed so far

A Since you left hospital on <Discharge date> have you had further hospital stays or used ANY OTHER health care services for any aspect of your health that you haven't included above?

- ☐ No - Go to Part 7
- ☐ Yes - Please give details below

B For EACH PROVIDER please answer the following

Type of service provider	Number of visits	Reason

Part 7. Comments

Your views are important to us. Please feel free to provide any other comments you have in the box below.

Thank you for help

If you would like to ask us any questions about completing the questionnaire please email or call:

CALORIES Team
[redacted]
[redacted]