TAGS - SUPPLEMENTARY MATERIAL 1

Patient paperwork, Case Report Forms and Participant Questionnaires

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Participant Information Sheet

Version 2.0 23-02-2016

Treatment of Advanced Glaucoma Study (TAGS): A multicentre randomised controlled trial comparing primary medical treatment with primary trabeculectomy for people with newly diagnosed advanced glaucoma.

PART 1

1. Invitation

You are being invited to take part in a research study. Before you decide whether or not to take part, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully, and discuss it with others if you wish.

PART 1 tells you the purpose of this study and what will happen to you if you take part.

PART 2 gives you more detailed information about the conduct of the study.

Please ask us if there is anything that is not clear, or if you would like more information. Take time to decide whether or not you wish to take part.

BACKGROUND TO THE CONDITION

Glaucoma is a disease of the eye that occurs when the pressure of the fluid inside the eye is too high. It usually affects both eyes, although one may be more severely affected than the other. Glaucoma is very common; around 2% of the UK population over the age of 40 have the condition. This rate increases as people get older and as many as 10% of those in their 80s are affected. Glaucoma is the second most common reason for registering people as visually impaired in the UK. People with

advanced glaucoma (those who have more severe visual field loss) have an increased risk of further progression and blindness.

Glaucoma is treated by using eye drops (medical) or by an operation (surgery) to lower eye pressure.

The two methods of lowering eye pressure that we will investigate in the TAGS study are:

- An operation called a trabeculectomy which allows the fluid to leave the eye more easily.

and

- Medical care which may require up to four different eye drops to be used.

2. What is the purpose of the study?
Reducing pressure is currently the only effective treatment for glaucoma. Both the treatments described above are commonly and successfully used in the NHS to reduce pressure but we do not know which treatment is better to prevent patients with advanced glaucoma from losing further vision. In the TAGS study we aim to find out which option is best. We will recruit 440 participants from NHS hospitals throughout the UK. The study will help us to find the best treatment of patients with advanced glaucoma in the future.

3. Why have I been invited to take part?
You have been chosen because you have been diagnosed with advanced glaucoma in at least one of your eyes and treatment is required to lower your eye pressure to prevent further visual loss.

4. Do I have to take part?
No. It is up to you to decide whether or not to take part.

If you decide to take part you will be given this information sheet to keep and be asked to sign a consent form to show that you understand what is involved when taking part in this study. If you decide to take part you are free to leave the study at any time and without giving a reason.

If you leave the study, we will still keep records about the treatment given to you, unless you object, as these are valuable to the study. If you decide to leave the study at any time, or decide not to take part, the quality of care you receive will not be affected.

5. What will happen if I take part?

Patients who agree to take part in TAGS will be given either medical (eye drops) or surgical (trabeculectomy) treatment. The particular treatment given to each person in the study will be decided by a computer system. This is called randomisation. Randomisation is similar to tossing a coin to decide which group you are entered into and is important to make sure that the results of the study are accurate.

If you decide to take part, neither you nor your doctor can decide which treatment you will receive. There is an equal chance you will be placed into either treatment group.

If you are happy to take part in the TAGS study you will be asked some questions to make sure that your circumstances mean you are suitable to take part in the study. If you are suitable, you will be asked to sign a consent form and complete the first questionnaire. Your details will be entered into a computer system and you will be allocated to receive one of the two treatment procedures. The doctors and nurses treating you will not be involved in your procedure allocation and have no control over what group you are put in. Both procedures are suitable for the treatment of your glaucoma and are currently used in the NHS.

You can find further information about the two treatments in section 7.

6. What do I have to do?

To collect the information we need, everyone in the study will be sent questionnaires by post approximately 1, 3, 6, 18 and 27 months after you join the study. The questionnaires ask about your vision and general health.

We will send you up to two reminders and will aim to contact you by post, email and/or telephone, taking into account which communication method is best for you. If you are in the surgery group we will ask you to complete another questionnaire before your operation.

After your treatment you will be asked to come back to an outpatient clinic at your hospital to check how you are getting on. We will ask you to complete questionnaires about your vision while you are in the clinic at around 4, 12 and 24 months after you join the study; we will also collect information about your treatment at these visits. Participating in this clinical trial will not affect the care you receive for your glaucoma

All the clinical care that you receive during the study will be the same as the standard care that is usually given within the NHS.

In addition to collecting information about your clinical condition we will also collect information about your income and what you spend in relation to your glaucoma care. This information is important as it will allow researchers to determine which treatments are best value for money. You may decline to provide this information if you wish

The study nurse and/or doctor involved in the study will also collect information from your NHS records during the time you are in the study.

Glaucoma is a lifelong condition and we want to make sure that the treatments we give have a long-term benefit. To this end, we aim to apply for funding to extend this study so we can look at longer-term outcomes (up to 10 years from when you started participating in the study). If this extension is funded we would like to continue to include you in the study for this longer period. We will use the same questionnaires that are currently used in this study, which we will ask you to complete every couple of years at most. We would also collect information from your medical records about your eye health and your glaucoma treatment. This will not require any extra visits to hospital clinics for you as your glaucoma will continue to be treated in the NHS for the rest of your life and the information we will be collecting will be part of your routine care.

Data for all participants in the study, including those who withdraw, will be kept securely for a minimum of 15 years.

7. What are the treatments being tested?

Group name	Procedure
Eye drops	• You will be started on one or more medication(s) at your first hospital visit. Your doctor will decide what type(s) of eye drops you need. • The medications you receive may later change if your doctor thinks you need more treatment for your glaucoma • If eye drops do not control your eye pressure it is normal for surgery (trabeculectomy) to be undertaken
Trabeculectomy	• This will happen within 3 months • Involves making a small hole in your eye • Day case procedure (but may require hospital admission) • Can be done under either a local or a general anaesthetic • Surgery normally takes about 40-60 minutes to complete • If both your eyes need surgery, there will usually be a wait of around two to three months between your first and second operations. • While waiting for surgery you will be treated with eye drops to lower the pressure

Waiting times for treatment will reflect current care in the NHS and we expect the procedure will be carried out in around three months of you agreeing to take part. Individual patient needs will be taken into consideration.

8. What are the alternatives for diagnosis or treatment?

Eye drops or trabeculectomy are the two most common treatments for people with advanced glaucoma. Laser treatment can also be used to treat glaucoma but is not often used to treat patients with advanced glaucoma.

9. What are the side effects of any treatment received when taking part?

If you do decide to take part in the study, you must report any problems you have to your study nurse or doctor. There is also a contact number

given at the end of this information sheet for you to phone if you become worried at any time.

There are no expected risks or disadvantages to participating in TAGS. Whichever group you are allocated to, your care will be overseen by an experienced consultant ophthalmologist (eye doctor) and any surgery performed will be done by a trained and experienced glaucoma specialist. Steps are always taken to make sure that any possible risks are minimised. As part of routine care, you will be well informed of potential risks.

The reported side effects of eye drops include:-

Common (greater than 1 in 10)
Redness*
Stinging*
Itching*
Transient blurred vision
Eyes watering*
Ocular discomfort*

Occasional (between 1 in 10 and 1 in 50)
Allergy*
Eyelash growth
Change in skin colour around eye
Change in iris colour
Shortness of breath
Unpleasant taste in mouth
Dry mouth

Uncommon (less than 1 in 50)
Fatigue
Kidney stones
Skin rash
Cataract formation
Retinal detachment

* In some case these symptoms may be due to preservatives in the drops – if this is the case preservative free drops can be used.

Reported trabeculectomy side effects include:-

Common (greater than 1 in 10)
Discomfort
Blurred vision
Cataract formation within 5 years

Occasional (between 1 in 10 and 1 in 50)
Pressure too low
Leak from operation site

Uncommon (less than 1 in 50)
Infection
Severe loss of vision (less than 1 in 500)
Bleeding in the eye

Both surgery and medical treatments are often used in the NHS for treating glaucoma patients. Although all these complications are well-recognised, many patients do not suffer any problems and most of the side effects are mild.

10. What are other possible disadvantages and risks of taking part?
For Women:
The eye drops might harm an unborn child; therefore you should not take part in this study if you are pregnant, breast-feeding or you intend to become pregnant during the study. If you are a woman who could become pregnant, you will be asked to have a pregnancy test (urine) before taking part.

To take part in TAGS you must agree to use a reliable form of contraception during the trial (if taking eye drops). This should be continued for at least three months after the treatment has finished.

11. What are the possible benefits of taking part?
We cannot promise the study will help you but by taking part in this study you will be directly helping us to inform the treatment of future patients diagnosed with glaucoma. The results of the study will help plan effective services offered by the NHS.

You will receive the same health care from your doctors whether you choose to participate in the study or not.

12. What happens when the research study stops?

Your doctor will continue your care and treatment as standard. If the study is stopped earlier than expected for any reason, you will be told and your continuing care will be arranged

13. What if there is a problem?

If you have a concern about any aspect of this study, you should ask to speak with the researchers who will do their best to answer your question. If you remain unhappy and wish to complain formally, you can do this through the NHS Complaints Procedure. Details are available from the hospital.

In the event that something does go wrong and you are harmed during the research study there are no special compensation arrangements. If you are harmed and this is due to someone's negligence then you may have grounds for a legal action for compensation but you may have to pay your legal costs. The normal National Health Service complaints mechanisms will still be available to you.

14. Will my taking part in this study be kept confidential?

Yes. All the information about your participation in this study will be kept confidential. Details are included in Part 2.

This completes Part 1 of the Information Sheet.

If the information in Part 1 has interested you and you are considering participation, please continue to read Part 2 before making any decision.

PART 2

15. What if new information becomes available?

Sometimes during the course of a clinical trial, new, relevant information becomes available on the treatments that are being studied. If this happens, we will tell you about it and discuss with you whether you want to or should continue in the study. If you decide to withdraw, we will make arrangements for your care to continue. If you decide to continue in the study you will be asked to sign a new consent form.

On receiving new information, we might consider it to be in your best interests to withdraw you from the study. If so, we will explain the reasons and arrange for your care to continue.

If the study is stopped for any other reason, you will be told why and your continuing care will be arranged.

16. What will happen if I don't want to carry on with the study?
You can withdraw from the study at any time, but you will need to continue attending appointments with your ophthalmologist and/or optometrist to have your glaucoma monitored as part of your standard care. It is normal that your glaucoma will be monitored for the rest of your life.

17. Will my part in this study be kept confidential?
If you consent to take part in this study, your records will remain strictly confidential at all times. The information will be held securely on paper and electronically at your treating hospital and the registered clinical trials unit (CHaRT) managing this research under the provisions of the 1998 Data Protection Act. Your name will not be passed to anyone else outside the research team or the sponsor, who is not involved in the trial. You will be allocated a trial number, which will be used as a code to identify you on all trial forms.

Information will be transferred from your hospital site to the clinical trial centre (CHaRT) organizing the research, to enable questionnaires to be sent to you and analysis of the study results. This will be done by mail and electronically. Personal details like your name and address will be sent separately to any clinical results collected for the trial. All other records will have your name removed and will only feature your unique study number and date of birth.

Your records will be available to people authorised to work on the trial but may also need to be made available to people authorised by the Research Sponsor, which is the organisation responsible for ensuring that the study is carried out correctly. A copy of your consent form may be sent to the Research Sponsor during the course of the study. By signing the consent form you agree to this access for the current study and any further research that may be conducted in relation to it, even if you withdraw from the current study.

The information collected about you may also be shown to authorised people from the UK Regulatory Authority; this is to ensure that the study is carried out to the highest possible scientific standards. All will have a duty of confidentiality to you as a research participant.

If you withdraw consent from further study treatment, unless you object, your data will remain on file and will be included in the final study analysis.

In line with Good Clinical Practice guidelines, at the end of the study, your data will be securely archived for a minimum of 15 years. Arrangements for confidential destruction will then be made.

With your permission, your GP, and other doctors who may be treating you, will be notified that you are taking part in this study.

Other researchers may wish to access data from this study in the future (this will not include names, addresses or dates of birth, and it is not possible to identify participants from the data). If this is the case, the consultant leading the study will ensure that the other researchers comply with legal, data protection and ethical guidelines.

18. Informing your General Practitioner (GP)
If you participate in the study we will tell your GP you are taking part, but only with your permission. We will also ask your GP to contact us if you visit them with any problems that may relate to your glaucoma treatment.

19. What will happen to any samples I give?
We are not taking any samples as part of this study

20. Will any genetic testing be done?
No, there is no plan to undertake genetic testing

21. What will happen to the results of this clinical trial?
The results of the study will be used to make recommendations on treatments for patients with advanced glaucoma. The results of this study will also be published in scientific journals and presented at scientific meetings. You will not be identified in any publication of results of the study. We will let you know the results of the study when it is finished unless you tell us that you do not wish to know.

22. Who is organising and funding this clinical trial?
The study has been designed by UK ophthalmology medical doctors and researchers. Patients will be recruited at different hospitals throughout the UK. The Nottingham University Hospitals NHS Trust will act as sponsor for the research.

The study is being funded by the UK National Institute for Health Research (NIHR), Health Technology Assessment (HTA) Programme. It

is being co-ordinated by The Centre for Healthcare Randomised Trials (CHaRT), a UKCRC registered clinical trials unit, at the University of Aberdeen.

23. Who has reviewed the study?

All research in the NHS is looked at by an independent group of people called a Research Ethics Committee, to protect your safety, rights, wellbeing and dignity. This study has been reviewed and given a favourable opinion by the NHS by Derby 1 Research Ethics Committee.

The study has also been reviewed and approved by the Research & Innovation department of Nottingham University Hospitals NHS Trust and of your local Research and Development Office.

24. Contact for further information

You are encouraged to ask any questions you wish, before, during or after your treatment. If you have any questions about the study, please speak to your study nurse or doctor, who will be able to provide you with up to date information about the drug(s)/procedure(s) involved. If you wish to read the research on which this study is based, please ask your study nurse or doctor. If you require any further information or have any concerns while taking part in the study please contact the local study team whose contact information is given at the end of this Patient Information Leaflet.

For further information about trabeculectomy surgery the International Glaucoma Association provides a "glaucoma buddy" service where it is possible to speak to a patient who has previously undergone trabeculectomy and will discuss the surgery with you. This service can be accessed through the IGA Sightline Service at 01233 648170.

If you decide you would like to take part then please read and sign the consent form. You will be given a copy of this information sheet and the consent form to keep. A copy of the consent form will be filed in your patient notes, one will be filed with the study records and one may be sent to the Research Sponsor.

You can have more time to think this over if you are at all unsure.

Thank you for taking the time to read this information sheet and for considering this study.

If you have any questions or would like any more information, please contact:

Study Office contact details:

TAGS Study Office
Centre for Healthcare Randomised Trials (CHaRT)
Health Services Research Unit
University of Aberdeen
3rd Floor, Health Sciences Building
Foresterhill
Aberdeen AB25 2ZD

Telephone: *+44 (0)1224 438196*

Email:*tags@abdn.ac.uk*

Website:*http://www.tagsstudy.co.uk*

Local contact details:

<<Insert contact details of local PI and/or Research Nurse>>

<<Insert contact details of local patient advice and liaison service>>

TREATMENT OF ADVANCED GLAUCOMA STUDY (TAGS)

Consent Form

Participant Study Number

Participant Initials: .... **Principal Investigator: ....**

Treatment of Advanced Glaucoma Study

Please **INITIAL** each box

1. I confirm that I have read and understand the information leaflet dated 23-02-2016 (Version 2.0) for the above study and have had the opportunity to ask questions. ☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time without my medical care or legal rights being affected. ☐
3. I understand that information relevant to the TAGS study may be collected from my hospital and NHS records, including Office of National Statistics (ONS) and NHS central registers. Relevant information may be looked at by authorised individuals from the Sponsor for the study and the UK Regulatory Authority in order to check that the study is being carried out correctly. ☐
4. I understand my personal contact details will be kept confidentially and securely by the study office in Aberdeen. I agree that the study coordinators can use my contact details to send me study questionnaires and to contact me by post. ☐
5. I understand that even if I withdraw from the above study, the data collected from me will be used in analysing the results of the trial, unless I specifically withdraw consent for this. ☐
6. I consent to the storage including electronic, of personal information for the purposes of this study. I understand that any information that could identify me will be kept strictly confidential and that no personal information will be included in the study report or other publication. ☐
7. I agree that my GP, or any other doctor treating me, will be notified of my participation in this study. ☐
8. I agree to continue to participate in a long-term follow-up of TAGS should funding to extend the study by up to 10 years be agreed (please delete to indicate). yes / no
9. I am willing to be asked in the future if I would be willing to take part in other relevant research. (please delete to indicate). yes / no
10. I agree to take part in the study. ☐

Your signature (participant) ____________________

Your name in block capitals ____________________

Date ____________________

To be completed by the local team member taking consent:

I confirm that I have explained to the person named above, the nature and purpose of the study and the procedures involved.

Signature ____________________

Name in block capitals ____________________

Date ____________________

Original to be retained and filed in the site file, 1 copy to patient, 1 copy to be filed in patient's notes, 1 copy to trial office.

TAGS Trial Office, Centre for Healthcare Randomised Trials (CHaRT), Health Services Research Unit, University of Aberdeen, Scotland, AB25 2ZD
Tel 01224 438196; Fax 01224 438165; Email: tags@abdn.ac.uk

Version: 3.0 Date: 15/01/2016

NHS
National Institute for Health Research

Contents

#	Form	Version	Date
1	Eligibility checklist	1.3	27 Nov 2014
2	Personal Details	1.1	19 May 2014
3	Baseline visit and randomisation	1.3	7 August 2014
4	Surgery details	1.0	7 March 2014
5	4-month visit	1.3	7 August 2014
6	12-month visit	1.3	7 August 2014
7	24-month visit	2.0	5 April 2014
8	Serious adverse event report form	1.1	13 May 2014
9	Change of status form	2.0	5 August 2014

Erratum

1. Need for cataract surgery: implemented on 1.6.2015, a label was added to revise Section 1 of the follow-up CRFs (4-, 12- and 24-months) to capture information about whether the patient had had cataract surgery.

2. 12- and 24-month CRFs: In Section 2 when documenting Hospital Outpatient Visits and medication changes to avoid duplicating data you have already collected please look at events **since the last study visit** **NOT** since the baseline visit.

3. 24-month CRF: implemented on 9.5.2016, a label was added to revise page 10 to repeat the baseline CRF

TAGS: Eligibility Checklist

Patient Name: ______________________________

To be eligible for the study the following criteria must be met:

	Yes	No
1) Severe glaucomatous visual field loss (Hodapp classification) in one or both eyes at presentation.	☐	☐

Hodapp classification of glaucoma severity [has any of the following]:

	Please specify: VF1	VF2
1. MD < -12.00dB,	☐	☐
2. More than 50% of points defective in the pattern deviation probability plot at the 5% level,	☐	☐
3. More than 20 points defective at the 1% level,	☐	☐
4. A point in the central 5 degrees has a sensitivity of 0-dB,	☐	☐
5. Points within 5 degrees of fixation under 15 dB sensitivity in both upper and lower hemi-fields.	☐	☐

	Yes	No
2) Open angle glaucoma including pigment dispersion glaucoma, pseudoexfoliative glaucoma and normal tension glaucoma.	☐	☐
3) Willingness to participate in the trial.	☐	☐
4) Ability to provide informed consent.	☐	☐
5) Over 18 years of age.	☐	☐
6) Females of child-bearing potential must have a negative urine test for pregnancy and agree to use a reliable method of contraception for the duration of her inclusion in the trial and three months thereafter.	☐	☐

A female is considered to be of childbearing potential unless she is without a uterus or is post-menopausal and has been amenorrheic for at least 12 consecutive months.

	Yes	No
7) None of the following conditions apply:	☐	☐

a. Inability to undergo incisional surgery due to inability to lie flat or unsuitable for anaesthetic.
b. High-risk of trabeculectomy failure such as previous conjunctival surgery, complicated cataract surgery.
c. Secondary glaucomas, and primary angle-closure glaucoma.
d. Females who are:
   i. pregnant,
   ii. nursing,
   iii. planning a pregnancy,
   iv. of childbearing potential not using a reliable method of contraception.

Name: ______________________ Signature: ______________________ Date: __________

TAGS PERSONAL DETAILS CRF

(Store securely and separately from baseline CRF).

Study number ☐☐☐☐☐

PATIENT DETAILS (Sticker may be used below)

Title: Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other ☐

First name: ☐

Surname: ☐

Date of birth D D / M M / Y Y Y Y ☐ Male ☐ Female

Address ☐

Postcode: ☐☐☐☐☐☐☐

Contact telephone Number ☐

CONSULTANT DETAILS

Initials ☐ Surname ☐

GP DETAILS

Initials ☐ Surname ☐

Address ☐

Pregnancy

Female of child-bearing potential? Yes ☐ No ☐

If YES, negative pregnancy test recorded? ☐

Ethnicity

Caucasian ☐ Asian - Oriental ☐

Afro-Caribbean ☐ Asian – India/Pakistan/Bangladesh ☐

Other (specify) ☐ ________________ Mixed heritage ☐

Baseline visit and randomisation

Please use the following list in conjunction with the comprehensive guide to procedures in the TAGS Study Guide and the TAGS Standard Operation Manual.

Checklist - Please initial when completed		*Initials*
1	Eligibility checklist completed and signed by doctor	
2	Consent form completed	
3	Baseline Questionnaire completed	
4	Personal Details CRF completed	
5	Patient randomised, informed of randomisation group and next step	
6	Patient study number added to CRF and Questionnaire	
7	Surgery appointment booked (if applicable)	
8	4-month appointment booked	
9	Study database updated with all information in CRFs and Questionnaire	

Physical Examinations - Please initial when completed		*Initials*
1	Medical History (including current glaucoma medication)	
2	ETDRS-Visual Acuity (Right, Left, **and** Binocular)	
3	Central Corneal Thickness	
4	Intraocular pressure	
5	Lens status	
6	Humphrey Visual Fields (upload files to study website. Print out a hard copy for the CRF).	
7	Esterman Visual Field	
8	Glaucoma Diagnosis	

TAGS BASELINE CRF

Study number | | | | | |

Date of Baseline Assessment DD / MM / YYYY

Date of Diagnosis of glaucoma DD / MM / YYYY

Section 1 - Medical History

Is the patient on any glaucoma medication? (include any holding treatment issued when diagnosed. *Please indicate medication below*). ☐ Yes ☐ No

Please indicate current medications and date of initiation

	Right Eye	Left Eye
Pg analogue	DDMMYYYY	DDMMYYYY
β-blocker	DDMMYYYY	DDMMYYYY
CA inhibitor	DDMMYYYY	DDMMYYYY
α-agonist	DDMMYYYY	DDMMYYYY
Pilocarpine	DDMMYYYY	DDMMYYYY
Diamox	DDMMYYYY	DDMMYYYY

Co-morbidity	**Right**	**Left**
AMD	☐	☐
Vascular occlusion	☐	☐
Diabetic Retinopathy	☐	☐
Cataract	☐	☐
Other (please indicate)	☐ ________	☐ ________

Section 2 - Visual Acuity

1. ETDRS distance visual acuity for RIGHT eye

Circle each letter/ number the patient correctly identifies at 4 metres and record the total number of letters read correctly in the column to the right. If the patient reads less than 20 letters, then move the patient to 1 metre (Note: Add +0.75 sphere if tested at 1 metre) and record the number of letters read correctly. If the patient is unable to read letters correctly at both 4 metres and 1 metre, then the visual Acuity Score is recorded as 0 and patient should be tested for HM, CF, LP and NLP.

4 - metre distance:

Row	Acuity Equivalent	Letters	Number correct at 4 metres
1	20/200	N C K Z O	
2	20/160	R H S D K	
3	20/125	D O V H R	
4	20/100	C Z R H S	
5	20/80	O N H R C	
6	20/63	D K S N V	
7	20/50	Z S O K N	
8	20/40	C K D N R	
9	20/32	S R Z K D	
10	20/25	H Z O V C	
11	20/20	N V D O K	
12	20/16	V H C N O	
13	20/12.5	S V H C Z	
14	20/10	O Z D V K	

1 – metre distance:

Row	Acuity Equivalent	Letters	Number correct at 1 metre
1	20/800	N C K Z O	
2	20/640	R H Z D K	
3	20/500	D O V H R	
4	20/400	C Z R H S	
5	20/320	O N H R C	
6	20/250	D K S N V	

If zero letters are read correctly at 4M or 1M

indicate best visual acuity for RIGHT eye:

☐ Count Fingers }
☐ Hand Motion } @ ______________
(distance)
☐ Light Perception
☐ No Light Perception/ Artificial Eye

Calculate Visual Acuity Score – RIGHT eye:	
A. Total number correct at 4 metres:	______
B. If A ≥ 20, enter 30, otherwise enter a zero (0):	______
C. Total number correct at 1 metre (if not tested, enter a zero):	______
RIGHT EYE: Sum of A, B and C above:	______

N.B. Letter (or numbers) may vary according to charts used

2. ETDRS distance visual acuity for LEFT eye

4 - metre distance:

Row	Acuity Equivalent	Letters	Number correct at 4 metres
1	20/200	D S R K N	
2	20/160	C K Z O H	
3	20/125	O N R K D	
4	20/100	K Z V D C	
5	20/80	V S H Z O	
6	20/63	H D K C R	
7	20/50	C S R H N	
8	20/40	S V Z D K	
9	20/32	N C V O Z	
10	20/25	R H S D V	
11	20/20	S N R O H	
12	20/16	O D H K R	
13	20/12.5	Z K C S N	
14	20/10	C R H D V	

1 – metre distance:

Row	Acuity Equivalent	Letters	Number correct at 1 metre
1	20/800	D S R K N	
2	20/640	C K Z O H	
3	20/500	O N R K D	
4	20/400	K Z V D C	
5	20/320	V S H Z O	
6	20/250	H D K C R	

If zero letters are read correctly at 4M or 1M

indicate best visual acuity for LEFT eye:

- ☐ Count Fingers }
- ☐ Hand Motion } @ ____________ *(distance)*
- ☐ Light Perception
- ☐ No Light Perception/ Artificial Eye

Calculate Visual Acuity Score – LEFT eye:	
A. Total number correct at 4 metres:	____________
B. If A ≥ 20, enter 30, otherwise enter a zero (0):	____________
C. Total number correct at 1 metre (if not tested, enter a zero):	____________
LEFT EYE: Sum of A, B and C above:	____________

N.B. Letter (or numbers) may vary according to charts used

3. ETDRS distance visual acuity for BOTH eyes

4 - metre distance:

Row	Acuity Equivalent	Letters	Number correct at 4 metres
1	20/200	N C K Z O	
2	20/160	R H S D K	
3	20/125	D O V H R	
4	20/100	C Z R H S	
5	20/80	O N H R C	
6	20/63	D K S N V	
7	20/50	Z S O K N	
8	20/40	C K D N R	
9	20/32	S R Z K D	
10	20/25	H Z O V C	
11	20/20	N V D O K	
12	20/16	V H C N O	
13	20/12.5	S V H C Z	
14	20/10	O Z D V K	

1 – metre distance:

Row	Acuity Equivalent	Letters	Number correct at 1 metre
1	20/800	N C K Z O	
2	20/640	R H Z D K	
3	20/500	D O V H R	
4	20/400	C Z R H S	
5	20/320	O N H R C	
6	20/250	D K S N V	

If zero letters are read correctly at 4M or 1M

indicate best visual acuity for BOTH eyes:

- ☐ Count Fingers
- ☐ Hand Motion

} @ __________ *(distance)*

- ☐ Light Perception
- ☐ No Light Perception/ Artificial Eye

Calculate Visual Acuity Score – BOTH eyes:	
A. Total number correct at 4 metres:	________
B. If A ≥ 20, enter 30, otherwise enter a zero (0):	________
C. Total number correct at 1 metre (if not tested, enter a zero):	________
BOTH EYES: Sum of A, B and C above:	________

N.B. Letter (or numbers) may vary according to charts used

Section 3 - Central Corneal Thickness

Central Corneal Thickness: Right eye [ ] μm Left eye [ ] μm

Section 4 - Intraocular Pressure

IOP – at **DIAGNOSIS**, UNTREATED, 2 readings (if within 3 mm Hg – if not take third measurement)						
	Right Eye			**Left Eye**		
1st reading (Goldmann Applanation):			mm Hg			mm Hg
2nd reading (Goldmann Applanation):			mm Hg			mm Hg
3rd reading (Goldmann Applanation):			mm Hg			mm Hg
Mean						

IOP at baseline evaluation (if different from diagnosis), IOP– 2 readings (if within 3 mm Hg – if not take third measurement)						
	Right Eye			**Left Eye**		
1st reading (Goldmann Applanation):			mm Hg			mm Hg
2nd reading (Goldmann Applanation):			mm Hg			mm Hg
3rd reading (Goldmann Applanation):			mm Hg			mm Hg
Mean						

Mires equilibrated by ____________________

IOP recorded by ____________________

Target IOP as per Canadian Consensus Guidance	**Right Eye**			**Left Eye**		
Target IOP estimate			mm Hg			mm Hg

Lens Status

Eye	**Phakic**	**Pseudophakic**	**Aphakic**
RIGHT eye	☐	☐	☐
LEFT eye	☐	☐	☐

Section 5 - Visual fields *(Humphrey 24.2 SITA standard)*

Visual Fields unreliable if false positive > 15%

Baseline 1

Date:

Right Eye:	Reliable	☐	Unreliable	☐	Not done	☐
Left Eye:	Reliable	☐	Unreliable	☐	Not done	☐

If visual fields reliable, please enter MD in dB of the VF

Right Eye:	**+/-**	☐	MD	☐	dB
			PSD	☐	
Left Eye:	**+/-**	☐	MD	☐	dB
			PSD	☐	

If perimetry undertaken, has a copy for each eye been added to the CRF file — Yes ☐ No ☐

If No, why? ______________________________________

Has an electronic record of the VF been saved to disc — Yes ☐ No ☐

If No, why? ______________________________________

Baseline 2

Date:

Right Eye:	Reliable	☐	Unreliable	☐	Not done	☐
Left Eye:	Reliable	☐	Unreliable	☐	Not done	☐

If visual fields reliable, please enter MD in dB of the second VF

Right Eye:	**+/-**	☐	MD	☐	dB
			PSD	☐	
Left Eye:	**+/-**	☐	MD	☐	dB
			PSD	☐	

If perimetry undertaken, has a copy for each eye been added to the CRF file — Yes ☐ No ☐

If No, why? ______________________________________

Has an electronic record of the VF been saved to disc — Yes ☐ No ☐

If No, why? ______________________________________

Esterman VF test:

Has an electronic record of the Esterman VF been saved to disc — Yes ☐ No ☐

If No, why? ______________________________________

Glaucoma Diagnosis

Primary Open Angle Glaucoma (including NTG) ☐
Pigment Dispersion Syndrome ☐
Pseudoexfoliation Syndrome ☐
Other: - ☐

DIAGNOSIS for **RIGHT** eye	☐ Advanced glaucoma	☐ Non-advanced glaucoma	☐ Neither
DIAGNOSIS for **LEFT** eye	☐ Advanced glaucoma	☐ Non-advanced glaucoma	☐ Neither

Is the patient eligible to be registered as sight impaired (SI)?
No ☐
SI ☐
Severe SI ☐

Has participant completed the TAGS Participant Baseline Questionnaire? Yes ☐ No ☐
If No, why? ______________________________

RANDOMISATION INFORMATION

Telephone Randomisation Service Number	0800 2802 307
Web Address	www.tagsstudy.co.uk

Gender	Male	☐	Female	☐
Are both eyes eligible?	Yes	☐	No	☐
Which is the nominated index eye	Right	☐	Left	☐

*If both eyes are eligible the participant will receive the allocated intervention to both eyes. The eye with the **least severe** (better MD) disease will be the **index eye**. If both eyes are equivalent in terms of disease severity or IOP then the participant will nominate the **index eye**. If only one eye is eligible this is the **index eye** the fellow eye is treated as indicated clinically.

Study number ☐☐☐☐☐

Please indicate what group the patient has been randomised to — Surgical ☐ Medical ☐

Surgery

Please use the following list in conjunction with the comprehensive guide to procedures in the TAGS Study Guide and the TAGS Standard Operation Manual.

Index Eye Checklist - Please initial when completed	***Initials***
1 Pre-trabeculectomy Questionnaire completed	
2 Surgery CRF completed	
3 Study database updated with all information in CRF and Questionnaire	

Fellow Eye Checklist –Please initial when completed (if needed)	***Initials***
1 Pre-trabeculectomy Questionnaire completed	
2 Surgery CRF completed	
3 Study database updated with all information in CRF	

TAGS - Surgery CRF

Study number ☐☐☐☐☐

Date of visit D D / M M / Y Y Y Y

***PATIENT DETAILS (*Sticker may be used below)**

CONSULTANT DETAILS

Date of surgery: ____________________________________

Reason for surgery

Study allocation	☐
Uncontrolled IOP	☐
Visual Field progression	☐
Drop intolerance/allergy	☐
Patient preference	☐
Other: ________________________________	☐

Section 1 - Medical History

Is the patient on:		Systemic medications		Stopped before surgery	
	Warfarin	☐ Yes	☐ No	☐ Yes	☐ No
	Aspirin	☐ Yes	☐ No	☐ Yes	☐ No
	NSAID	☐ Yes	☐ No	☐ Yes	☐ No
	Dabigatran	☐ Yes	☐ No	☐ Yes	☐ No
	Clopidogrel	☐ Yes	☐ No	☐ Yes	☐ No
	Gingko Biloba	☐ Yes	☐ No	☐ Yes	☐ No

Anaesthetist	Consultant	☐	____	**Other Theatre Staff**	Scrub nurse	☐	____
	Fellow	☐	____		Nurse runner	☐	____
	Other	☐	____		ODA	☐	____
	Grade:	_____	____		*Grade:*	_____	____

Surgery Technique/ Disposables/Equipment

Traction suture		Corneal	☐	
		Superior rectus	☐	
Conjunctival Flap		Fornix	☐	
		Limbal	☐	
MMC	Dose	0.2mg/ml	☐	
		0.4mg/ml	☐	
		other	☐	----------------
	Duration	3 minutes	☐	
		other	☐	----------------

Scleral flap sutures	Interrupted	☐	Number _______
	Releasable	☐	Number _______
	Adjustable	☐	Number _______

	Yes	**No**
A/C maintainer	☐	☐
Preop Iopidine	☐	☐
Per-operative Miochol	☐	☐
Peroperative Viscoelastic	☐	☐
Subconjunctival antibiotic	☐	☐
Subconjunctival steroid	☐	☐

Equipment Used

Intraocular tray	☐	☐
Diamond knife	☐	☐
15* blade	☐	☐
Kelly punch	☐	☐
Khaw punch	☐	☐
AC maintainer	☐	☐

Number or sutures used ____

Suture types

Silk	☐
Nylon	☐
Vicryl	☐
Other	☐

Any per-operative complications?

None	☐
Flap dehiscence	☐
Hyphema	☐
Button hole	☐
Other	☐ ______________________________

TAGS - Surgery CRF

Study number | | | | | |

Date of visit D D / M M / Y Y Y Y

PATIENT DETAILS **(Sticker may be used below)**

CONSULTANT DETAILS

Date of surgery: ____________________________________

Reason for surgery

Study allocation	☐
Uncontrolled IOP	☐
Visual Field progression	☐
Drop intolerance/allergy	☐
Patient preference	☐
Other: ________________________________	☐

Section 1 - Medical History

Is the patient on:

	Systemic medications		Stopped before surgery	
Warfarin	☐ Yes	☐ No	☐ Yes	☐ No
Aspirin	☐ Yes	☐ No	☐ Yes	☐ No
NSAID	☐ Yes	☐ No	☐ Yes	☐ No
Dabigatran	☐ Yes	☐ No	☐ Yes	☐ No
Clopidogrel	☐ Yes	☐ No	☐ Yes	☐ No
Gingko Biloba	☐ Yes	☐ No	☐ Yes	☐ No

Preop drops	**Right**	**Left**
Pg analogue	☐	☐
B-blocker	☐	☐
CA inhibitor	☐	☐
A-agonist	☐	☐
Parasympathomimetic	☐	☐

	Yes	**No**
Diamox	☐	☐

Preop IOP		**Right**	**Left**
		________	________
Side of surgery		☐	☐

General

Anaesthetic Regional block ☐ ____________ General ☐

Admission type Day Case ☐ Overnight stay ☐

Time into OR	Time out of OR

Staffing

Surgeon

		Number
Consultant	☐	____
Fellow	☐	____
Other	☐	____
Grade:	_____	____

Surgeon Assistant

		Number
Consultant	☐	____
Fellow	☐	____
Trainee	☐	____
Scrub nurse	☐	____

Anaesthetist	Consultant	☐	____	**Other Theatre Staff**	Scrub nurse	☐	____
	Fellow	☐	____		Nurse runner	☐	____
	Other	☐	____		ODA	☐	____
	Grade:	_____	____		*Grade:*	_____	____

Surgery Technique/ Disposables/Equipment

Traction suture		Corneal	☐	
		Superior rectus	☐	
Conjunctival Flap		Fornix	☐	
		Limbal	☐	
MMC	Dose	0.2mg/ml	☐	
		0.4mg/ml	☐	
		other	☐	----------------
	Duration	3 minutes	☐	
		other	☐	----------------

Scleral flap sutures	Interrupted	☐	Number ________
	Releasable	☐	Number ________
	Adjustable	☐	Number ________

	Yes	**No**
A/C maintainer	☐	☐
Preop Iopidine	☐	☐
Per-operative Miochol	☐	☐
Peroperative Viscoelastic	☐	☐
Subconjunctival antibiotic	☐	☐
Subconjunctival steroid	☐	☐

Equipment Used

Intraocular tray	☐	☐
Diamond knife	☐	☐
15* blade	☐	☐
Kelly punch	☐	☐
Khaw punch	☐	☐
AC maintainer	☐	☐

Number or sutures used ___

Suture types

Silk	☐
Nylon	☐
Vicryl	☐
Other	☐

Any per-operative complications?

None	☐
Flap dehiscence	☐
Hyphema	☐
Button hole	☐
Other	☐ ________________________________

4-month clinic visit

Please use the following list in conjunction with the comprehensive guide to procedures in the TAGS Study Guide and the TAGS Standard Operation Manual.

Checklist - Please initial when completed		***Initials***
1	4-month Questionnaire completed	
2	Patient study number added to CRF and Questionnaire	
3	12-month appointment booked	
4	Study database updated with all information in CRF and Questionnaire	

Physical Examinations - Please initial when completed		***Initials***
1	Adverse events recorded (check medical notes and ask patient).	
2	Hospital visits recorded (overnight, day case and outpatient)	
3	Further interventions recorded (if any)	
4	Current glaucoma medication recorded.	
5	Medication changes recorded	
6	ETDRS-Visual Acuity (Right, Left, **and** Binocular)	
7	Intraocular pressure	
8	Humphrey Visual Fields (upload files to study website. Print out a hard copy for the CRF).	

TAGS - 4 MONTH CRF

Study number | | | | | |

Date of visit D D / M M / Y Y Y Y

Section 1

Since the last study visit:

Has the patient had cataract surgery?

Intervention Undertaken	Right	Left	Date
Phaco + IOL	☐	☐	d d m m y y
Phaco + IOL	☐	☐	d d m m y y

Has the patient had a trabeculectomy? (If not please skip to Section 2)

Intervention Undertaken	Right	Left	Date
Trabeculectomy	☐	☐	d d m m y y
Trabeculectomy	☐	☐	d d m m y y

Since the last study visit (baseline) have any of the following occurred?

If Yes, what (*please tick all that are appropriate and include the date*)?

Event	Right	Left	Date
Irreversible loss of ≥10 ETDRS letter	☐	☐	d d m m y y
Shallow anterior chamber	☐	☐	d d m m y y
Early Bleb leak	☐	☐	d d m m y y
Corneal Epithelial defect	☐	☐	d d m m y y
Persistent Uveitis	☐	☐	d d m m y y
Conjunctival button hole	☐	☐	d d m m y y
Malignant glaucoma	☐	☐	d d m m y y
Macular oedema	☐	☐	d d m m y y
Hyphema	☐	☐	d d m m y y
Choroidal effusion	☐	☐	d d m m y y
Suprachoroidal haemorrhage	☐	☐	d d m m y y
Iris incarceration	☐	☐	d d m m y y
Hypotony requiring intervention	☐	☐	d d m m y y
Retinal detachment	☐	☐	d d m m y y
Corneal decompensation	☐	☐	d d m m y y
Late Bleb Leak	☐	☐	d d m m y y
Blebitis	☐	☐	d d m m y y
Endophthalmitis	☐	☐	d d m m y y
Ptosis	☐	☐	d d m m y y

Since the last study visit (baseline) have any of the following interventions been undertaken?

If Yes, what (*please tick all that are appropriate and include the date*)?

Intervention	**Right**	**Left**	**Date**
Massage	☐	☐	d d m m y y
	☐	☐	d d m m y y
	☐	☐	d d m m y y
	☐	☐	d d m m y y
	☐	☐	d d m m y y
	☐	☐	d d m m y y
Releasable release (please circle)			
Adjustment / suturelysis / releasable release	☐	☐	d d m m y y
Adjustment / suturelysis / releasable release	☐	☐	d d m m y y
Adjustment / suturelysis / releasable release	☐	☐	d d m m y y
Adjustment / suturelysis / releasable release	☐	☐	d d m m y y
Adjustment / suturelysis / releasable release	☐	☐	d d m m y y
5-FU injection	☐	☐	d d m m y y
	☐	☐	d d m m y y
	☐	☐	d d m m y y
	☐	☐	d d m m y y
	☐	☐	d d m m y y
Steroid injection	☐	☐	d d m m y y
	☐	☐	d d m m y y
	☐	☐	d d m m y y
	☐	☐	d d m m y y
Needling + 5-FU injection	☐	☐	d d m m y y
	☐	☐	d d m m y y
	☐	☐	d d m m y y
	☐	☐	d d m m y y
Bleb resuturing	☐	☐	d d m m y y
AC reformation	☐	☐	d d m m y y
Bleb revision	☐	☐	d d m m y y
Phaco + IOL	☐	☐	d d m m y y
Other …..	☐	☐	d d m m y y

Was **overnight** admission required for any of the above? Yes ☐ No ☐

If Yes, please provide admission and discharge date(s)

	Date of Admission	Date of Discharge
Admission 1	D D M M Y Y Y Y	D D M M Y Y Y Y
Admission 2	D D M M Y Y Y Y	D D M M Y Y Y Y
Admission 3	D D M M Y Y Y Y	D D M M Y Y Y Y

Was a **day case** admission required for any of the above? Yes ☐ No ☐

If Yes, please provide admission date(s)

	Date of Admission
Admission 1	D D M M Y Y Y Y
Admission 2	D D M M Y Y Y Y
Admission 3	D D M M Y Y Y Y

Section 2

Hospital Outpatient Visits

Please record the dates and reason of any hospital visits related to glaucoma care since the baseline visit.

Number	Date	Reason
1	d d m m y y	
2	d d m m y y	
3	d d m m y y	
4	d d m m y y	
5	d d m m y y	
6	d d m m y y	
7	d d m m y y	
8	d d m m y y	
9	d d m m y y	
10	d d m m y y	
11	d d m m y y	
12	d d m m y y	
13	d d m m y y	
14	d d m m y y	
15	d d m m y y	
16	d d m m y y	

Current anti-glaucoma medication (*prior to clinical assessment)*

Is the patient on any anti-glaucoma medication? Yes ☐ No ☐

If Yes, please indicate medication and date (DD/MM/YYYY) initiated

	Right Eye	Left Eye
Pg analogue	D D M M Y Y Y Y	D D M M Y Y Y Y
β-blocker	D D M M Y Y Y Y	D D M M Y Y Y Y
CA inhibitor	D D M M Y Y Y Y	D D M M Y Y Y Y
α-agonist	D D M M Y Y Y Y	D D M M Y Y Y Y
Pilocarpine	D D M M Y Y Y Y	D D M M Y Y Y Y
Diamox	D D M M Y Y Y Y	D D M M Y Y Y Y

Other *(please specify medication(s))*

____________	D D M M Y Y Y Y	D D M M Y Y Y Y
____________	D D M M Y Y Y Y	D D M M Y Y Y Y

How many different bottles of medication are they currently using (please circle)

0 1 2 3 >3

Medication Changes

Since the last study visit (baseline) please indicate how many glaucoma related medication changes have been made

Medication	Stop date	Eye	Reason for stopping
	d d m m y y		
	d d m m y y		
	d d m m y y		
	d d m m y y		
Medication	**Start date**	**Eye**	**Reason for starting**
	d d m m y y		
	d d m m y y		
	d d m m y y		
	d d m m y y		

Has the patient had any adverse events to the **either** eye including medication intolerence? Yes ☐ No ☐

If "**Yes**", please give details*

**If there are any serious adverse events (meaning death, or unexpected adverse events not listed above but deemed related to participation in TAGS which involve or prolong hospitalisation), please complete a Serious Adverse Event form.*

Section 3

Vision and Ocular Examination

Visual Acuity Assessment
(1=RIGHT EYE. 2=LEFT EYE. 3=BOTH EYES)

1. ETDRS DISTANCE VISUAL ACUITY/RIGHT EYE

Circle each letter/ number the patient correctly identifies at 4 metres and record the total number of letters read correctly in the column to the right. If the patient reads less than 20 letters, then move the patient to 1 metre (Note: Add +0.75 sphere if tested at 1 metre) and record the number of letters read correctly. If the patient is unable to read letters correctly at both 4 metres and 1 metre, then the visual Acuity Score is recorded as 0 and patient should be tested for HM, CF, LP and NLP.

4 - metre distance:

Row	Acuity Equivalent	Letters	Number correct at 4 metres
1	20/200	N C K Z O	
2	20/160	R H S D K	
3	20/125	D O V H R	
4	20/100	C Z R H S	
5	20/80	O N H R C	
6	20/63	D K S N V	
7	20/50	Z S O K N	
8	20/40	C K D N R	
9	20/32	S R Z K D	
10	20/25	H Z O V C	
11	20/20	N V D O K	
12	20/16	V H C N O	
13	20/12.5	S V H C Z	
14	20/10	O Z D V K	

1 – metre distance:

Row	Acuity Equivalent	Letters	Number correct at 1 metre
1	20/800	N C K Z O	
2	20/640	R H Z D K	
3	20/500	D O V H R	
4	20/400	C Z R H S	
5	20/320	O N H R C	
6	20/250	D K S N V	

If zero letters are read correctly at 4M or 1M indicate best visual acuity for RIGHT eye:

- ☐ Count Fingers }
- ☐ Hand Motion } @ _______ *(distance)*
- ☐ Light Perception
- ☐ No Light Perception/ Artificial Eye

Calculate Visual Acuity Score – RIGHT eye:	
A. Total number correct at 4 metres:	________
B. If A ≥ 20, enter 30, otherwise enter a zero (0):	________
C. Total number correct at 1 metre (if not tested, enter a zero):	________
RIGHT EYE: Sum of A, B and C above:	________

N.B. Letter (or numbers) may vary according to charts used

2. ETDRS DISTANCE VISUAL ACUITY/LEFT EYE

4 - metre distance:

Row	Acuity Equivalent	Letters	Number correct at 4 metres
1	20/200	D S R K N	______
2	20/160	C K Z O H	______
3	20/125	O N R K D	______
4	20/100	K Z V D C	______
5	20/80	V S H Z O	______
6	20/63	H D K C R	______
7	20/50	C S R H N	______
8	20/40	S V Z D K	______
9	20/32	N C V O Z	______
10	20/25	R H S D V	______
11	20/20	S N R O H	______
12	20/16	O D H K R	______
13	20/12.5	Z K C S N	______
14	20/10	C R H D V	______

1 – metre distance:

Row	Acuity Equivalent	Letters	Number correct at 1 metre
1	20/800	D S R K N	______
2	20/640	C K Z O H	______
3	20/500	O N R K D	______
4	20/400	K Z V D C	______
5	20/320	V S H Z O	______
6	20/250	H D K C R	______

If zero letters are read correctly at 4M or 1M

indicate best visual acuity for LEFT eye:

☐ Count Fingers }
☐ Hand Motion } @ ______
(distance)
☐ Light Perception
☐ No Light Perception/ Artificial Eye

Calculate Visual Acuity Score – LEFT eye:	
A. Total number correct at 4 metres:	______
B. If A ≥ 20, enter 30, otherwise enter a zero (0):	______
C. Total number correct at 1 metre (if not tested, enter a zero):	______
LEFT EYE: Sum of A, B and C above:	______

N.B. Letter (or numbers) may vary according to charts used

3. ETDRS DISTANCE VISUAL ACUITY/BOTH EYES

4 - metre distance:

Row	Acuity Equivalent	Letters	Number correct at 4 metres
1	20/200	N C K Z O	
2	20/160	R H S D K	
3	20/125	D O V H R	
4	20/100	C Z R H S	
5	20/80	O N H R C	
6	20/63	D K S N V	
7	20/50	Z S O K N	
8	20/40	C K D N R	
9	20/32	S R Z K D	
10	20/25	H Z O V C	
11	20/20	N V D O K	
12	20/16	V H C N O	
13	20/12.5	S V H C Z	
14	20/10	O Z D V K	

1 – metre distance:

Row	Acuity Equivalent	Letters	Number correct at 1 metre
1	20/800	N C K Z O	
2	20/640	R H Z D K	
3	20/500	D O V H R	
4	20/400	C Z R H S	
5	20/320	O N H R C	
6	20/250	D K S N V	

If zero letters are read correctly at 4M or 1M

indicate best visual acuity for BOTH eyes:

- ☐ Count Fingers }
- ☐ Hand Motion } @ ____________ *(distance)*
- ☐ Light Perception
- ☐ No Light Perception/ Artificial Eye

Calculate Visual Acuity Score – BOTH eyes:	
A. Total number correct at 4 metres:	
B. If A ≥ 20, enter 30, otherwise enter a zero (0):	
C. Total number correct at 1 metre (if not tested, enter a zero):	
BOTH EYES: Sum of A, B and C above:	

N.B. Letter (or numbers) may vary according to charts used

Reasons for Irreversible loss of ≥10 ETDRS letter (if present):

IOP evaluation

IOP – 2 readings (if within 3 mm Hg – if not take third measurement)						
	Right Eye			**Left Eye**		
1st reading (Goldmann Applanation):			mm Hg			mm Hg
2nd reading (Goldmann Applanation):			mm Hg			mm Hg
3rd reading (Goldmann Applanation):			mm Hg			mm Hg
Mean						

Mires equilibrated by ____________________

IOP recorded by ____________________

Visual fields *(Humphrey 24.2 SITA standard)*

VF1 - Date

D	D	M	M	Y	Y	Y	Y

Right Eye: Reliable ☐ Unreliable ☐ Not done ☐

Left Eye: Reliable ☐ Unreliable ☐ Not done ☐

If visual fields reliable, please enter MD in dB of the VF

Right Eye: **+/-** ☐ MD ☐ dB
PSD ☐

Left Eye: **+/-** ☐ MD ☐ dB
PSD ☐

If perimetry undertaken, has a copy for each eye been added to the CRF file Yes ☐ No ☐

If No, why? ______________________________

Has an electronic record of the VF been saved to disc Yes ☐ No ☐

If No, why? ______________________________

VF2 - Date

D	D	M	M	Y	Y	Y	Y

Right Eye: Reliable ☐ Unreliable ☐ Not done ☐

Left Eye: Reliable ☐ Unreliable ☐ Not done ☐

If visual fields reliable, please enter MD in dB of the second VF

Right Eye: **+/-** ☐ MD ☐ dB
PSD ☐

Left Eye: **+/-** ☐ MD ☐ dB
PSD ☐

If perimetry undertaken, has a copy for each eye been added to the CRF file Yes ☐ No ☐

If No, why? ______________________________

Has an electronic record of the VF been saved to disc Yes ☐ No ☐

If No, why? ______________________________

Has the patient completed the study questionnaire? **Yes** ☐ **No** ☐

If No, why? ______________________________

12-month clinic visit

Please use the following list in conjunction with the comprehensive guide to procedures in the TAGS Study Guide and the TAGS Standard Operation Manual.

Checklist - Please initial when completed		***Initials***
1	12-month Questionnaire completed	
2	Patient study number added to CRF and Questionnaire	
3	24-month appointment booked	
4	Study database updated with all information in CRF and Questionnaire	

Physical Examinations - Please initial when completed		***Initials***
1	Adverse events recorded (check medical notes and ask patient).	
2	Hospital visits recorded (overnight, day case and outpatient)	
3	Further interventions recorded (if any)	
4	Current glaucoma medication recorded.	
5	Medication changes recorded	
6	ETDRS-Visual Acuity (Right, Left, **and** Binocular)	
7	Intraocular pressure	
8	Humphrey Visual Fields (upload files to study website. Print out a hard copy for the CRF).	

Treatment of Advanced Glaucoma Study

TAGS - 12 MONTH CRF

Study number | | | | | |

Date of visit D D / M M / Y Y Y Y

Section 1

Since the last study visit:

Has the patient had cataract surgery?

Intervention Undertaken	Right	Left	Date
Phaco + IOL	☐	☐	d d m m y y
Phaco + IOL	☐	☐	d d m m y y

Has the patient had a trabeculectomy? (If not please skip to Section 2)

Intervention Undertaken	Right	Left	Date
Trabeculectomy	☐	☐	d d m m y y
Trabeculectomy	☐	☐	d d m m y y

Since the last study visit (4 month) have any of the following occurred?

If Yes, what (*please tick all that are appropriate and include the date*)?

Event	Right	Left	Date
Irreversible loss of ≥10 ETDRS letter	☐	☐	d d m m y y
Shallow anterior chamber	☐	☐	d d m m y y
Early Bleb leak	☐	☐	d d m m y y
Corneal Epithelial defect	☐	☐	d d m m y y
Persistent Uveitis	☐	☐	d d m m y y
Conjunctival button hole	☐	☐	d d m m y y
Malignant glaucoma	☐	☐	d d m m y y
Macular oedema	☐	☐	d d m m y y
Hyphema	☐	☐	d d m m y y
Choroidal effusion	☐	☐	d d m m y y
Suprachoroidal haemorrhage	☐	☐	d d m m y y
Iris incarceration	☐	☐	d d m m y y
Hypotony requiring intervention	☐	☐	d d m m y y
Retinal detachment	☐	☐	d d m m y y
Corneal decompensation	☐	☐	d d m m y y
Late Bleb Leak	☐	☐	d d m m y y
Blebitis	☐	☐	d d m m y y
Endophthalmitis	☐	☐	d d m m y y
Ptosis	☐	☐	d d m m y y

Since the last study visit (4 month) have any of the following interventions been undertaken?

If Yes, what (*please tick all that are appropriate and include the date*)?

Intervention	Right	Left	Date
Massage	☐	☐	d d m m y y
	☐	☐	d d m m y y
	☐	☐	d d m m y y
	☐	☐	d d m m y y
	☐	☐	d d m m y y
	☐	☐	d d m m y y
Releasable release (please circle)			
Adjustment / suturelysis / releasable release	☐	☐	d d m m y y
Adjustment / suturelysis / releasable release	☐	☐	d d m m y y
Adjustment / suturelysis / releasable release	☐	☐	d d m m y y
Adjustment / suturelysis / releasable release	☐	☐	d d m m y y
Adjustment / suturelysis / releasable release	☐	☐	d d m m y y
5-FU injection	☐	☐	d d m m y y
	☐	☐	d d m m y y
	☐	☐	d d m m y y
	☐	☐	d d m m y y
	☐	☐	d d m m y y
Steroid injection	☐	☐	d d m m y y
	☐	☐	d d m m y y
	☐	☐	d d m m y y
	☐	☐	d d m m y y
Needling + 5-FU injection	☐	☐	d d m m y y
	☐	☐	d d m m y y
	☐	☐	d d m m y y
	☐	☐	d d m m y y
Bleb resuturing	☐	☐	d d m m y y
AC reformation	☐	☐	d d m m y y
Bleb revision	☐	☐	d d m m y y
Phaco + IOL	☐	☐	d d m m y y
Other …..	☐	☐	d d m m y y

Was **overnight** admission required for any of the above? Yes ☐ No ☐

If Yes, please provide admission and discharge date(s)

	Date of Admission	Date of Discharge
Admission 1	D D M M Y Y Y Y	D D M M Y Y Y Y
Admission 2	D D M M Y Y Y Y	D D M M Y Y Y Y
Admission 3	D D M M Y Y Y Y	D D M M Y Y Y Y

Was a **day case** admission required for any of the above? Yes ☐ No ☐

If Yes, please provide admission date(s)

	Date of Admission
Admission 1	D D M M Y Y Y Y
Admission 2	D D M M Y Y Y Y
Admission 3	D D M M Y Y Y Y

Section 2

Hospital Outpatient Visits

Please record the dates and reason of any hospital visits related to glaucoma care since the baseline visit.

Number	Date	Reason
1	d d m m y y	
2	d d m m y y	
3	d d m m y y	
4	d d m m y y	
5	d d m m y y	
6	d d m m y y	
7	d d m m y y	
8	d d m m y y	
9	d d m m y y	
10	d d m m y y	
11	d d m m y y	
12	d d m m y y	
13	d d m m y y	
14	d d m m y y	
15	d d m m y y	
16	d d m m y y	

Current anti-glaucoma medication *(prior to clinical assessment)*

Is the patient on any anti-glaucoma medication? Yes ☐ No ☐

If Yes, please indicate medication and date (DD/MM/YYYY) initiated

	Right Eye	Left Eye
Pg analogue	D D M M Y Y Y Y	D D M M Y Y Y Y
β-blocker	D D M M Y Y Y Y	D D M M Y Y Y Y
CA inhibitor	D D M M Y Y Y Y	D D M M Y Y Y Y
α-agonist	D D M M Y Y Y Y	D D M M Y Y Y Y
Pilocarpine	D D M M Y Y Y Y	D D M M Y Y Y Y
Diamox	D D M M Y Y Y Y	D D M M Y Y Y Y

Other *(please specify medication(s))*

____________	D D M M Y Y Y Y	D D M M Y Y Y Y
____________	D D M M Y Y Y Y	D D M M Y Y Y Y

How many different bottles of medication are they currently using (please circle)

0 1 2 3 >3

Medication Changes

Since the last study visit (baseline) please indicate how many glaucoma related medication changes have been made

Medication	Stop date	Eye	Reason for stopping
	d d m m y y		
	d d m m y y		
	d d m m y y		
	d d m m y y		
Medication	**Start date**	**Eye**	**Reason for starting**
	d d m m y y		
	d d m m y y		
	d d m m y y		
	d d m m y y		

Has the patient had any adverse events to the **either** eye including medication intolerence? Yes ☐ No ☐

If "**Yes**", please give details*

**If there are any serious adverse events (meaning death, or unexpected adverse events not listed above but deemed related to participation in TAGS which involve or prolong hospitalisation), please complete a Serious Adverse Event form.*

Vision and Ocular Examination

Refraction

	+/-	Sphere		+/-	Cyl		Axis
Right eye	☐	☐☐ . ☐☐	/	☐	☐☐ . ☐☐	x	☐
Left eye	☐	☐☐ . ☐☐	/	☐	☐☐ . ☐☐	x	☐

Section 3

Vision and Ocular Examination

Visual Acuity Assessment
(1=RIGHT EYE. 2=LEFT EYE. 3=BOTH EYES)

1. ETDRS DISTANCE VISUAL ACUITY/RIGHT EYE

Circle each letter/ number the patient correctly identifies at 4 metres and record the total number of letters read correctly in the column to the right. If the patient reads less than 20 letters, then move the patient to 1 metre (Note: Add +0.75 sphere if tested at 1 metre) and record the number of letters read correctly. If the patient is unable to read letters correctly at both 4 metres and 1 metre, then the visual Acuity Score is recorded as 0 and patient should be tested for HM, CF, LP and NLP.

4 - metre distance:

Row	Acuity Equivalent	Letters	Number correct at 4 metres
1	20/200	N C K Z O	______
2	20/160	R H S D K	______
3	20/125	D O V H R	______
4	20/100	C Z R H S	______
5	20/80	O N H R C	______
6	20/63	D K S N V	______
7	20/50	Z S O K N	______
8	20/40	C K D N R	______
9	20/32	S R Z K D	______
10	20/25	H Z O V C	______
11	20/20	N V D O K	______
12	20/16	V H C N O	______
13	20/12.5	S V H C Z	______
14	20/10	O Z D V K	______

1 – metre distance:

Row	Acuity Equivalent	Letters	Number correct at 1 metre
1	20/800	N C K Z O	______
2	20/640	R H Z D K	______
3	20/500	D O V H R	______
4	20/400	C Z R H S	______
5	20/320	O N H R C	______
6	20/250	D K S N V	______

If zero letters are read correctly at 4M or 1M

indicate best visual acuity for RIGHT eye:

- ☐ Count Fingers }
- ☐ Hand Motion } @ ______ *(distance)*
- ☐ Light Perception
- ☐ No Light Perception/ Artificial Eye

Calculate Visual Acuity Score – RIGHT eye:	
A. Total number correct at 4 metres:	______
B. If A ≥ 20, enter 30, otherwise enter a zero (0):	______
C. Total number correct at 1 metre (if not tested, enter a zero):	______
RIGHT EYE: Sum of A, B and C above:	______

N.B. Letter (or numbers) may vary according to charts used

2. ETDRS DISTANCE VISUAL ACUITY/LEFT EYE

4 - metre distance:

Row	Acuity Equivalent	Letters	Number correct at 4 metres
1	20/200	D S R K N	
2	20/160	C K Z O H	
3	20/125	O N R K D	
4	20/100	K Z V D C	
5	20/80	V S H Z O	
6	20/63	H D K C R	
7	20/50	C S R H N	
8	20/40	S V Z D K	
9	20/32	N C V O Z	
10	20/25	R H S D V	
11	20/20	S N R O H	
12	20/16	O D H K R	
13	20/12.5	Z K C S N	
14	20/10	C R H D V	

1 – metre distance:

Row	Acuity Equivalent	Letters	Number correct at 1 metre
1	20/800	D S R K N	
2	20/640	C K Z O H	
3	20/500	O N R K D	
4	20/400	K Z V D C	
5	20/320	V S H Z O	
6	20/250	H D K C R	

If zero letters are read correctly at 4M or 1M

indicate best visual acuity for LEFT eye:

- ☐ Count Fingers
- ☐ Hand Motion } @ ________ *(distance)*
- ☐ Light Perception
- ☐ No Light Perception/ Artificial Eye

Calculate Visual Acuity Score – LEFT eye:	
A. Total number correct at 4 metres:	________
B. If A ≥ 20, enter 30, otherwise enter a zero (0):	________
C. Total number correct at 1 metre (if not tested, enter a zero):	________
LEFT EYE: Sum of A, B and C above:	________

N.B. Letter (or numbers) may vary according to charts used

3. ETDRS DISTANCE VISUAL ACUITY/BOTH EYES

4 - metre distance:

Row	Acuity Equivalent	Letters	Number correct at 4 metres
1	20/200	N C K Z O	
2	20/160	R H S D K	
3	20/125	D O V H R	
4	20/100	C Z R H S	
5	20/80	O N H R C	
6	20/63	D K S N V	
7	20/50	Z S O K N	
8	20/40	C K D N R	
9	20/32	S R Z K D	
10	20/25	H Z O V C	
11	20/20	N V D O K	
12	20/16	V H C N O	
13	20/12.5	S V H C Z	
14	20/10	O Z D V K	

1 – metre distance:

Row	Acuity Equivalent	Letters	Number correct at 1 metre
1	20/800	N C K Z O	
2	20/640	R H Z D K	
3	20/500	D O V H R	
4	20/400	C Z R H S	
5	20/320	O N H R C	
6	20/250	D K S N V	

If zero letters are read correctly at 4M or 1M

indicate best visual acuity for BOTH eyes:

- ☐ Count Fingers
- ☐ Hand Motion } @ ____________ *(distance)*
- ☐ Light Perception
- ☐ No Light Perception/ Artificial Eye

Calculate Visual Acuity Score – BOTH eyes:	
A. Total number correct at 4 metres:	____________
B. If A ≥ 20, enter 30, otherwise enter a zero (0):	____________
C. Total number correct at 1 metre (if not tested, enter a zero):	____________
BOTH EYES: Sum of A, B and C above:	____________

N.B. Letter (or numbers) may vary according to charts used

Reasons for Irreversible loss of ≥10 ETDRS letter (if present):

IOP evaluation

IOP – 2 readings (if within 3mm Hg – if not take third measurement)						
	Right Eye			Left Eye		
1st reading (Goldmann Applanation):			mm Hg			mm Hg
2nd reading (Goldmann Applanation):			mm Hg			mm Hg
3rd reading (Goldmann Applanation):			mm Hg			mm Hg
Mean						

Mires equilibrated by ____________________

IOP recorded by ____________________

Visual fields *(Humphrey 24.2 SITA standard)*

VF1 - Date | D | D | M | M | Y | Y | Y | Y |

Right Eye: Reliable ☐ Unreliable ☐ Not done ☐

Left Eye: Reliable ☐ Unreliable ☐ Not done ☐

If visual fields reliable, please enter MD in dB of the VF

Right Eye: **+/-** ☐ MD ☐ dB
PSD ☐

Left Eye: **+/-** ☐ MD ☐ dB
PSD ☐

If perimetry undertaken, has a copy for each eye been added to the CRF file Yes ☐ No ☐

If No, why? ____________________

Has an electronic record of the VF been saved to disc Yes ☐ No ☐

If No, why? ____________________

VF2 - Date | D | D | M | M | Y | Y | Y | Y |

Right Eye: Reliable ☐ Unreliable ☐ Not done ☐

Left Eye: Reliable ☐ Unreliable ☐ Not done ☐

If visual fields reliable, please enter MD in dB of the second VF

Right Eye: **+/-** ☐ MD ☐ dB
PSD ☐

Left Eye: **+/-** ☐ MD ☐ dB
PSD ☐

If perimetry undertaken, has a copy for each eye been added to the CRF file Yes ☐ No ☐

If No, why? ____________________

Has an electronic record of the VF been saved to disc Yes ☐ No ☐

If No, why? ____________________

Has the patient completed the study questionnaire? **Yes** ☐ **No** ☐

If No, why? ____________________

24-month clinic visit

Please use the following list in conjunction with the comprehensive guide to procedures in the TAGS Study Guide and the TAGS Standard Operation Manual.

Checklist - Please initial when completed	***Initials***
1 24-month Questionnaire completed	
2 Patient study number added to CRF and Questionnaire	
3 Study database updated with all information in CRF and Questionnaire	

Physical Examinations - Please initial when completed	***Initials***
1 Adverse events recorded (check medical notes and ask patient).	
2 Hospital visits recorded (overnight, day case and outpatient)	
3 Further interventions recorded (if any)	
4 Current glaucoma medication recorded.	
5 Medication changes recorded	
6 Formal refraction recorded	
6 ETDRS-Visual Acuity (Right, Left, **and** Binocular)	
7 Intraocular pressure	
8 Humphrey Visual Fields (upload files to study website. Print out a hard copy for the CRF).	
9 Esterman Visual Field	

Treatment of Advanced Glaucoma Study

TAGS - 24 MONTH CRF

Study number | | | | | |

Date of visit D D / M M / Y Y Y Y

Section 1

Since the last study visit:

Has the patient had cataract surgery?

Intervention Undertaken	**Right**	**Left**	**Date**
Phaco + IOL	☐	☐	d d m m y y
Phaco + IOL	☐	☐	d d m m y y

Has the patient had a trabeculectomy? (If not please skip to Section 2)

Intervention Undertaken	**Right**	**Left**	**Date**
Trabeculectomy	☐	☐	d d m m y y
Trabeculectomy	☐	☐	d d m m y y

Since the last study visit (12 month) have any of the following occurred?

If Yes, what (*please tick all that are appropriate and include the date*)?

Event	**Right**	**Left**	**Date**
Irreversible loss of ≥10 ETDRS letter	☐	☐	d d m m y y
Shallow anterior chamber	☐	☐	d d m m y y
Early Bleb leak	☐	☐	d d m m y y
Corneal Epithelial defect	☐	☐	d d m m y y
Persistent Uveitis	☐	☐	d d m m y y
Conjunctival button hole	☐	☐	d d m m y y
Malignant glaucoma	☐	☐	d d m m y y
Macular oedema	☐	☐	d d m m y y
Hyphema	☐	☐	d d m m y y
Choroidal effusion	☐	☐	d d m m y y
Suprachoroidal haemorrhage	☐	☐	d d m m y y
Iris incarceration	☐	☐	d d m m y y
Hypotony requiring intervention	☐	☐	d d m m y y
Retinal detachment	☐	☐	d d m m y y
Corneal decompensation	☐	☐	d d m m y y
Late Bleb Leak	☐	☐	d d m m y y
Blebitis	☐	☐	d d m m y y
Endophthalmitis	☐	☐	d d m m y y
Ptosis	☐	☐	d d m m y y

Since the last study visit (12 month) have any of the following interventions been undertaken?

If Yes, what (*please tick all that are appropriate and include the date*)

Intervention	**Right**	**Left**	**Date**
Massage	☐	☐	d d m m y y
	☐	☐	d d m m y y
	☐	☐	d d m m y y
	☐	☐	d d m m y y
	☐	☐	d d m m y y
	☐	☐	d d m m y y
Releasable release (please circle)			
Adjustment / suturelysis / releasable release	☐	☐	d d m m y y
Adjustment / suturelysis / releasable release	☐	☐	d d m m y y
Adjustment / suturelysis / releasable release	☐	☐	d d m m y y
Adjustment / suturelysis / releasable release	☐	☐	d d m m y y
Adjustment / suturelysis / releasable release	☐	☐	d d m m y y
5-FU injection	☐	☐	d d m m y y
	☐	☐	d d m m y y
	☐	☐	d d m m y y
	☐	☐	d d m m y y
	☐	☐	d d m m y y
Steroid injection	☐	☐	d d m m y y
	☐	☐	d d m m y y
	☐	☐	d d m m y y
	☐	☐	d d m m y y
Needling + 5-FU injection	☐	☐	d d m m y y
	☐	☐	d d m m y y
	☐	☐	d d m m y y
	☐	☐	d d m m y y
Bleb resuturing	☐	☐	d d m m y y
AC reformation	☐	☐	d d m m y y
Bleb revision	☐	☐	d d m m y y
Phaco + IOL	☐	☐	d d m m y y
Other …..	☐	☐	d d m m y y

Was **overnight** admission required for any of the above? Yes ☐ No ☐

If Yes, please provide admission and discharge date(s)

	Date of Admission	Date of Discharge
Admission 1	D D M M Y Y Y Y	D D M M Y Y Y Y
Admission 2	D D M M Y Y Y Y	D D M M Y Y Y Y
Admission 3	D D M M Y Y Y Y	D D M M Y Y Y Y

Was a **day case** admission required for any of the above? Yes ☐ No ☐

If Yes, please provide admission date(s)

	Date of Admission
Admission 1	D D M M Y Y Y Y
Admission 2	D D M M Y Y Y Y
Admission 3	D D M M Y Y Y Y

Section 2

Hospital Outpatient Visits

Please record the dates and reason of any hospital visits related to glaucoma care since the last study follow-up visit.

Number	Date	Reason
1	d d m m y y	
2	d d m m y y	
3	d d m m y y	
4	d d m m y y	
5	d d m m y y	
6	d d m m y y	
7	d d m m y y	
8	d d m m y y	
9	d d m m y y	
10	d d m m y y	
11	d d m m y y	
12	d d m m y y	
13	d d m m y y	
14	d d m m y y	
15	d d m m y y	
16	d d m m y y	

Current anti-glaucoma medication (*prior to clinical assessment)*

Is the patient on any anti-glaucoma medication? Yes ☐ No ☐

If Yes, please indicate medication and date (DD/MM/YYYY) initiated

	Right Eye	Left Eye
Pg analogue	D D M M Y Y Y Y	D D M M Y Y Y Y
β-blocker	D D M M Y Y Y Y	D D M M Y Y Y Y
CA inhibitor	D D M M Y Y Y Y	D D M M Y Y Y Y
α-agonist	D D M M Y Y Y Y	D D M M Y Y Y Y
Pilocarpine	D D M M Y Y Y Y	D D M M Y Y Y Y
Diamox	D D M M Y Y Y Y	D D M M Y Y Y Y

Other *(please specify medication(s))*

____________	D D M M Y Y Y Y	D D M M Y Y Y Y
____________	D D M M Y Y Y Y	D D M M Y Y Y Y

How many different bottles of medication are they currently using (please circle)

0 1 2 3 >3

Medication Changes

Since the last study visit (baseline) please indicate how many glaucoma related medication changes have been made

Medication	Stop date	Eye	Reason for stopping
	d d m m y y		
	d d m m y y		
	d d m m y y		
	d d m m y y		
Medication	**Start date**	**Eye**	**Reason for starting**
	d d m m y y		
	d d m m y y		
	d d m m y y		
	d d m m y y		

Has the patient had any adverse events to the **either** eye including medication intolerence? Yes ☐ No ☐

If "**Yes**", please give details*

**If there are any serious adverse events (meaning death, or unexpected adverse events not listed above but deemed related to participation in TAGS which involve or prolong hospitalisation), please complete a Serious Adverse Event form.*

Section 3

Has the patient been listed for trabeculectomy? **Yes** ☐ **No** ☐

Vision and Ocular Examination

A formal refraction **must be** performed at the final 24-month visit **before** the 24-month Visual Field tests.

Refraction

	+/-	Sphere		+/-	Cyl		Axis
Right eye	☐	☐☐ . ☐☐	/	☐	☐☐ . ☐☐	x	☐
Left eye	☐	☐☐ . ☐☐	/	☐	☐☐ . ☐☐	x	☐

Section 3

Vision and Ocular Examination

Visual Acuity Assessment
(1=RIGHT EYE. 2=LEFT EYE. 3=BOTH EYES)

1. ETDRS DISTANCE VISUAL ACUITY/RIGHT EYE

Circle each letter/ number the patient correctly identifies at 4 metres and record the total number of letters read correctly in the column to the right. If the patient reads less than 20 letters, then move the patient to 1 metre (Note: Add +0.75 sphere if tested at 1 metre) and record the number of letters read correctly. If the patient is unable to read letters correctly at both 4 metres and 1 metre, then the visual Acuity Score is recorded as 0 and patient should be tested for HM, CF, LP and NLP.

4 - metre distance:

Row	Acuity Equivalent	Letters	Number correct at 4 metres
1	20/200	N C K Z O	
2	20/160	R H S D K	
3	20/125	D O V H R	
4	20/100	C Z R H S	
5	20/80	O N H R C	
6	20/63	D K S N V	
7	20/50	Z S O K N	
8	20/40	C K D N R	
9	20/32	S R Z K D	
10	20/25	H Z O V C	
11	20/20	N V D O K	
12	20/16	V H C N O	
13	20/12.5	S V H C Z	
14	20/10	O Z D V K	

1 – metre distance:

Row	Acuity Equivalent	Letters	Number correct at 1 metre
1	20/800	N C K Z O	
2	20/640	R H Z D K	
3	20/500	D O V H R	
4	20/400	C Z R H S	
5	20/320	O N H R C	
6	20/250	D K S N V	

If zero letters are read correctly at 4M or 1M

indicate best visual acuity for RIGHT eye:

☐ Count Fingers }
☐ Hand Motion } @ ____________ *(distance)*
☐ Light Perception
☐ No Light Perception/ Artificial Eye

Calculate Visual Acuity Score – RIGHT eye:	
A. Total number correct at 4 metres:	________
B. If A ≥ 20, enter 30, otherwise enter a zero (0):	________
C. Total number correct at 1 metre (if not tested, enter a zero):	________
RIGHT EYE: Sum of A, B and C above:	________

N.B. Letter (or numbers) may vary according to charts used

2. ETDRS DISTANCE VISUAL ACUITY/LEFT EYE

4 - metre distance:

Row	Acuity Equivalent	Letters	Number correct at 4 metres
1	20/200	D S R K N	
2	20/160	C K Z O H	
3	20/125	O N R K D	
4	20/100	K Z V D C	
5	20/80	V S H Z O	
6	20/63	H D K C R	
7	20/50	C S R H N	
8	20/40	S V Z D K	
9	20/32	N C V O Z	
10	20/25	R H S D V	
11	20/20	S N R O H	
12	20/16	O D H K R	
13	20/12.5	Z K C S N	
14	20/10	C R H D V	

1 – metre distance:

Row	Acuity Equivalent	Letters	Number correct at 1 metre
1	20/800	D S R K N	
2	20/640	C K Z O H	
3	20/500	O N R K D	
4	20/400	K Z V D C	
5	20/320	V S H Z O	
6	20/250	H D K C R	

If zero letters are read correctly at 4M or 1M

indicate best visual acuity for LEFT eye:

☐ Count Fingers
☐ Hand Motion } @ ____________ *(distance)*
☐ Light Perception
☐ No Light Perception/ Artificial Eye

Calculate Visual Acuity Score – LEFT eye:	
A. Total number correct at 4 metres:	____________
B. If A ≥ 20, enter 30, otherwise enter a zero (0):	____________
C. Total number correct at 1 metre (if not tested, enter a zero):	____________
LEFT EYE: Sum of A, B and C above:	____________

N.B. Letter (or numbers) may vary according to charts used

3. ETDRS DISTANCE VISUAL ACUITY/BOTH EYES

4 - metre distance:

Row	Acuity Equivalent	Letters	Number correct at 4 metres
1	20/200	N C K Z O	
2	20/160	R H S D K	
3	20/125	D O V H R	
4	20/100	C Z R H S	
5	20/80	O N H R C	
6	20/63	D K S N V	
7	20/50	Z S O K N	
8	20/40	C K D N R	
9	20/32	S R Z K D	
10	20/25	H Z O V C	
11	20/20	N V D O K	
12	20/16	V H C N O	
13	20/12.5	S V H C Z	
14	20/10	O Z D V K	

1 – metre distance:

Row	Acuity Equivalent	Letters	Number correct at 1 metre
1	20/800	N C K Z O	
2	20/640	R H Z D K	
3	20/500	D O V H R	
4	20/400	C Z R H S	
5	20/320	O N H R C	
6	20/250	D K S N V	

If zero letters are read correctly at 4M or 1M

indicate best visual acuity for BOTH eyes:

- ☐ Count Fingers
- ☐ Hand Motion } @ ____________ *(distance)*
- ☐ Light Perception
- ☐ No Light Perception/ Artificial Eye

Calculate Visual Acuity Score – BOTH eyes:	
A. Total number correct at 4 metres:	________
B. If A ≥ 20, enter 30, otherwise enter a zero (0):	________
C. Total number correct at 1 metre (if not tested, enter a zero):	________
BOTH EYES: Sum of A, B and C above:	________

N.B. Letter (or numbers) may vary according to charts used

Reasons for Irreversible loss of ≥10 ETDRS letter (if present):

IOP evaluation

IOP – 2 readings (if within 3 mm Hg – if not take third measurement)						
	Right Eye			**Left Eye**		
1st reading (Goldmann Applanation):			mm Hg			mm Hg
2nd reading (Goldmann Applanation):			mm Hg			mm Hg
3rd reading (Goldmann Applanation):			mm Hg			mm Hg
Mean						

Mires equilibrated by ____________________

IOP recorded by ____________________

Visual fields *(Humphrey 24.2 SITA standard)*

VF1 - Date D D M M Y Y Y Y

Right Eye: Reliable ☐ Unreliable ☐ Not done ☐

Left Eye: Reliable ☐ Unreliable ☐ Not done ☐

If visual fields reliable, please enter MD in dB of the VF

Right Eye: **+/-** ☐ MD ☐ dB
PSD ☐

Left Eye: **+/-** ☐ MD ☐ dB
PSD ☐

If perimetry undertaken, has a copy for each eye been added to the CRF file Yes ☐ No ☐

If No, why? ____

Has an electronic record of the VF been saved to disc Yes ☐ No ☐

If No, why? ____

VF2 - Date | D | D | M | M | Y | Y | Y | Y |

Right Eye: Reliable ☐ Unreliable ☐ Not done ☐

Left Eye: Reliable ☐ Unreliable ☐ Not done ☐

If visual fields reliable, please enter MD in dB of the second VF

Right Eye: **+/-** ☐ MD ☐ dB
PSD ☐

Left Eye: **+/-** ☐ MD ☐ dB
PSD ☐

If perimetry undertaken, has a copy for each eye been added to the CRF file Yes ☐ No ☐

If No, why? ____________________

Has an electronic record of the VF been saved to disc Yes ☐ No ☐

If No, why? ____________________

Esterman VF test:

Has an electronic record of the Esterman VF been saved to disc Yes ☐ No ☐

If No, why? ____________________

Is the patient **ELIGIBLE** to be registered as sight impaired (SI)?
No ☐
SI ☐
Severe SI ☐

Has the patient been **REGISTERED** as sight impaired (SI)?
No ☐
SI ☐
Severe SI ☐

Date of Registration: ____|____|____

Has the patient completed the study questionnaire? **Yes** ☐ **No** ☐

If No, why? ____________________

Serious Adverse Event and Death report form

(More available from the TAGS Trial Office and on the study website at www.tagsstudy.co.uk)

Serious Adverse Event/Death Report Form

Study Number: | | | | | |

Record hospital visits (planned or unplanned) associated with further glaucoma treatment/ interventions on the relevant CRF (4-, 12-, 24-month visit).

This form should be completed for:

- Any SAEs expected or unexpected but related to the participant's advanced glaucoma treatment that are not further interventions (e.g. if a participant is admitted to hospital for treatment of infection).
- **ALL deaths (for any reason).**

Date of report	D	D	M	M	Y	Y	Y	Y

Initial Report ☐ **Follow Up Report** ☐

Subject Details:

Initials | | | | Date of Birth | D | D | M | M | Y | Y | Y | Y | Gender: Male ☐ Female ☐

NHS/CHI Number: | | | | | | | | | | |

Serious Adverse Event

Seriousness criteria (Check all that apply):

Resulted in death	☐	Life-threatening	☐	Hospitalisation/Prolongation of hospitalisation	☐
Persistent/Significant Disability/Incapacity	☐	Congenital anomaly/ Birth defect	☐	Other medically important condition	☐

Date of Event:	D	D	M	M	Y	Y	Y	Y

Brief details of adverse event:

Was the event related to a procedure required by the protocol? Yes ☐ No ☐
(see protocol section 8.2.2)

Is this an "expected" serious adverse event? Yes ☐ No ☐
(see protocol section 8.1.3 for list of potential expected events)

Other relevant history (e.g. diagnostics, allergies, etc)

Place where adverse event took place or was detected:

Details of any intervention required:

To be signed by the Principal Investigator or designee

I am the Principal Investigator Yes ☐ No ☐

If No, Please state designation

I confirm that this is a SAE

Name:
(PRINT)

Signature:

Date: D D M M Y Y Y Y

Change of Status

(More available from the TAGS Trial Office and on the study website at www.tagsstudy.co.uk)

CHANGE OF STATUS

Study number ☐☐☐☐☐

Date of change D D / M M / Y Y Y Y

Q1. Is this a post-randomisation exclusion? **Yes** ☐ **No** ☐ *(go to Q2)*
(i.e. the participant was not eligible for the study)

If Yes, please state reason for the post-randomisation exclusion in the box below

Q2. Is this change of status as a result of: **Loss to follow-up** ☐ Death* ☐

*Include if not collected or reported elsewhere

If necessary, please add further details for the change of status in the box below

Q3. Who has requested the change of status?

Participant ☐ **Clinician** ☐ **Other** ☐ *Please specify* ____________________

Q4. What does the change of status relate to? *(tick as many boxes as required)*

Having treatment/taking medication ☐

Attending follow-up clinics ☐

Completing further questionnaires ☐

Contact by telephone from a member of the TAGS team? ☐

Relevant outcome data being collected via hospital and GP records ☐
(only complete if participant explicitly requests this)

CHANGE OF STATUS

Study number ☐☐☐☐☐

Date of change D D / M M / Y Y Y Y

Q1. Is this a post-randomisation exclusion? **Yes** ☐ **No** ☐ *(go to Q2)*
(i.e. the participant was not eligible for the study)

If Yes, please state reason for the post-randomisation exclusion in the box below

Q2. Is this change of status as a result of: **Loss to follow-up** ☐ **Death*** ☐

*Include if not collected or reported elsewhere

If necessary, please add further details for the change of status in the box below

Q3. Who has requested the change of status?

Participant ☐ **Clinician** ☐ **Other** ☐ *Please specify* ____________________

Q4. What does the change of status relate to? *(tick as many boxes as required)*

Having treatment/taking medication ☐

Attending follow-up clinics ☐

Completing further questionnaires ☐

Contact by telephone from a member of the TAGS team? ☐

Relevant outcome data being collected via hospital and GP records ☐
(only complete if participant explicitly requests this)

INELIGIBLE/DECLINED FORM

Outline data on patients who are ineligible or who decline participation

Q1 **Date of attempted recruitment** D D / M M / Y Y Y Y

Q2 **Year of Birth** Y Y Y Y **Gender** (please tick) Male ☐ Female ☐

Q3 **Reasons for non-inclusion (PLEASE ANSWER FROM A, B or C & tick all reasons that apply):**

A) PATIENT DECLINED:

- Patient declined to give a reason ☐
- Does not want surgery ☐
- Does not wish to be randomised ☐
- Does not wish to participate in a trial ☐
- Preference for medical treatment or for surgery ☐
- Lifestyle factors e.g. work or family commitments. ☐
- Other Reason (please give details below): ☐

Details: --

B) INELIGIBLE – CLINICAL REASON:

- Visual fields did not meet criteria (e.g. deficit not severe enough or fields improved) ☐
- Unable to undergo incisional surgery ☐
- High risk of trabeculectomy failure ☐
- Secondary glaucomas and Primary Angle-Closure Glaucoma (PACG) ☐
- Female who is pregnant, nursing, planning a pregnancy or not using reliable contraception ☐
- Patient unable to provide informed consent (or understand/complete trial documentation) ☐
- Other clinical reason (please give details): ☐

Details: --

C) INELIGIBLE – OTHER REASON:

- Could not be randomised within 3 months of diagnosis ☐
- Unreliable visual fields ☐
- Patient did not attend appointments ☐
- Non-English speaker ☐
- Other non-clinical reason (please give details): ☐

Details: --

Signature: ______________________ Print Name: ______________________

Pregnancy Notification Form

FOR TRIAL OFFICE USE ONLY

R&D reference: 1 | 3 | 7 | 8 | 4 | 0

Centre ID: ☐☐☐

Eudract No.: 2 | 0 | 1 | 3 | 0 | 0 | 4 | 0 | 2 | 0 | 1 | 1

Subject ID: ☐☐☐☐☐

Subject initials: ☐☐☐

DO NOT SEND IDENTIFIABLE DATA OR SOURCE DOCUMENTS WITH THIS REPORT

1. MATERNAL INFORMATION

Date of Birth	Date of last menstrual period	Expected date of delivery
D D M M Y Y Y Y	D D M M Y Y Y Y	D D M M Y Y Y Y

Methods of contraception ______________________________

Contraception used as instructed

Yes ☐ **No** ☐ **Uncertain** ☐

2. MEDICAL HISTORY (include information on familial disorders, known risk factors or conditions that may affect the outcome of the pregnancy. If none mark N/A)

3. PREVIOUS OBSTETRIC HISTORY

	Gestation week	Outcome including any abnormalities
1		
2		
3		
4		
5		

4. DRUG INFORMATION (list all therapies taken prior to and during pregnancy)

Name of drug	Daily dose	Route	Date Started	Date Stopped	Treatment Start (week of pregnancy)	Treatment Stop (week of pregnancy)
			D D M M Y Y	D D M M Y Y	D D	D D
			D D M M Y Y	D D M M Y Y	D D	D D
			D D M M Y Y	D D M M Y Y	D D	D D
			D D M M Y Y	D D M M Y Y	D D	D D
			D D M M Y Y	D D M M Y Y	D D	D D
			D D M M Y Y	D D M M Y Y	D D	D D
			D D M M Y Y	D D M M Y Y	D D	D D

5. PRENATAL INFORMATION

Have any specific tests e.g. amniocentesis, ultrasound, maternal serum AFP, been performed during the pregnancy so far?

Yes ☐ **No** ☐ **Uncertain** ☐

If yes please specify test date and results:

Test		Date	Result
1		D D M M Y Y	
2		D D M M Y Y	
3		D D M M Y Y	

6. PREGNANCY OUTCOME

(a)Abortion **Yes** ☐ Date: D D M M Y Y Y Y **No** ☐ (go to 6b)

If yes: Therapeutic ☐ Planned ☐ Spontaneous ☐

Please specify the reason and any abnormalities (if known):

(b) Delivery **Yes** ☐ Date: D D M M Y Y Y Y **No** ☐

If yes: Normal ☐ Forceps/Ventouse ☐ Caesarean ☐

Maternal complications or problems related to birth:

7. MATERNAL PREGNANCY ASSOCIATED EVENTS

If the mother experiences an SAE during the pregnancy, please indicate here.

Complete a SAE form and submit it to the Trial Office immediately.

8. CHILD OUTCOME

Normal ☐	Abnormal ☐	Stillbirth ☐
If any abnormalities please specify and provide dates:		

Sex	Height (cm):	Weight (kg):	Head circumference (cm):	Agpar Scores:		
Male ☐ Female ☐				1 min:	5 mins:	10 mins:

9. ASSESSMENT OF SERIOUSNESS (OF PREGNANCY OUTCOME)

Non-serious	☐	Involved prolonged inpatient hospitalisation	☐	Results in persistent or significant disability/incapacity	☐
Life Threatening	☐	Congenital anomaly/birth defect	☐	Other significant medical events	☐

Mother died ☐									Stillbirth/neonate died ☐								
Date of death	D	D	M	M	Y	Y	Y	Y	Date of death	D	D	M	M	Y	Y	Y	Y

10. ASSESSMENT OF CAUSALITY (OF PREGNANCY OUTCOME)

Please indicate the relationship between pregnancy outcome:

Unrelated ☐ Possibly* ☐ Probably* ☐ Definitely* ☐

If any of the fields marked* have been checked, the outcome is considered RELATED to medication used in the management of the patient's glaucoma.

11. ADDITIONAL INFORMATION

12. INFORMATION SOURCE

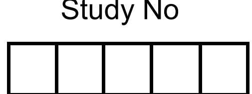
Name

Position

Address

Signature	Date of report	D	D	M	M	Y	Y	Y	Y

Study No



TAGS

Treatment of Advanced Glaucoma Study

A multicentre randomised controlled trial comparing primary medical treatment with primary trabeculectomy for people with newly diagnosed advanced glaucoma.

PARTICIPANT QUESTIONNAIRE

Thank you for helping us with our research.
We would be very grateful if you could complete this questionnaire.

CONFIDENTIAL

BASELINE

ISRCTN - 56878850

Version 1.3, 19 June 2015

TAGS is funded by the UK National Institute for Health Research (NIHR), Health Technology Assessment (HTA) Programme (12/35/38).

The following questionnaire is broken down into five sections (Section A - Section E as detailed below). Please work through all the sections as best you can from start to finish.

Some of the sections ask you to indicate your answers to the questions by placing a tick **(✓)** in the appropriate box, and other sections ask you to circle your answer out of a list that is provided. Please read the questions carefully and answer each one as accurately as you can.

If you have any difficulties reading the text or understanding the meaning of any questions, then please ask a TAGS member of staff or contact the central office in Aberdeen.

The sections covered in this questionnaire are as follows:

Section A: All about you

Section B: Visual Functioning Questionnaire (split into 3 parts):

Part 1 - General Health and Vision

Part 2 - Difficulty with activities

Part 3 - Response to vision problems

Section C: Describing your own health today

Section D: Health Utility Index

Section E: Describing your experience of Glaucoma

SECTION A – ALL ABOUT YOU

Before you fill in our main questionnaire it will help us to understand your answers better if we have a little background data from you first as covered in the following questions. PLEASE TICK THE APPROPRIATE BOXES. Please remember that the answers from all TAGS questionnaires are strictly confidential.

Please try to complete all the questions. Some of the sections ask you to indicate your answers to the questions by placing a tick **(✓)** in the appropriate box, and other sections ask you to circle your answer out of a list that is provided. Please read the questions carefully and answer each one as accurately as you can.

We would like to send you questionnaires in a text size that best suits your needs. In future would you like to receive questionnaires

In future I would like to receive questionnaires in this text size ☐

OR in future I would like to receive questionnaires in this text size ☐

A1. Which of the following best describes your main activity?

☐ In employment or self-employment
☐ Retired
☐ Seeking work
☐ Other *(please specify)* ______________________________
☐ Housework
☐ Student

A2. Did your education continue after the minimum school leaving age?

☐ Yes ☐ No

A3. Do you have a family history of glaucoma?

☐ Yes ☐ No

A4. How many times have you visited the optician in the last 10 years?

______________________________ times

SECTION B – VISUAL FUNCTIONING QUESTIONNAIRE (NEI-VFQ-25)

The following section is a survey with statements about problems, which involve your vision, or feelings that you have about your eye condition. After each question please choose the response that best describes your situation. Please take as much time as you need to answer each question. All your answers are confidential. In order for this survey to improve our knowledge about eye problems and how they affect your quality of life, your answers must be as accurate as possible. Remember, if you wear glasses or contact lenses, please answer all of the following questions as though you were wearing them.

INSTRUCTIONS:

1. In general we would like to have people try to complete these forms on their own. If you find that you need assistance, please feel free to ask the project staff and they will assist you.
2. Please answer every question (unless you are asked to skip questions because they don't apply to you).
3. Answer the questions by circling the appropriate number.
4. If you are unsure of how to answer a question, please give the best answer you can and make a comment in the left margin.
5. If you have any questions, please feel free to ask a member of the project staff, and they will be glad to help you.

STATEMENT OF CONFIDENTIALITY:

All information that would permit identification of any person who completed this questionnaire will be regarded as strictly confidential. Such information will be used only for the purposes of this study and will not be disclosed or released for any other purposes without prior consent, except as required by law.

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SECTION B - PART 1 GENERAL HEALTH AND VISION (NEI-VFQ-25)

B1: In general, would you say your overall health is:

(Circle One)

Excellent	1
Very Good	2
Good	3
Fair	4
Poor	5

B2: At the present time, would you say your eyesight using both eyes (with glasses or contact lenses, if you wear them) is excellent, good, fair, poor, or very poor or are you completely blind?

(Circle One)

Excellent	1
Good	2
Fair	3
Poor	4
Very Poor	5
Completely Blind	6

B3: How much of the time do you worry about your eyesight?

(Circle One)

None of the time	1
A little of the time	2
Some of the time	3
Most of the time	4
All of the time	5

B4: How much pain or discomfort have you had in and around your eyes (for example, burning, itching, or aching)? Would you say it is:

(Circle One)

None	1
Mild	2
Moderate	3
Severe, or	4
Very severe	5

SECTION B - PART 2 DIFFICULTY WITH ACTIVITIES

The next questions are about how much difficulty, if any, you have doing certain activities wearing your glasses or contact lenses if you use them for that activity.

B5: How much difficulty do you have reading ordinary print in newspapers? Would you say you have:

(Circle One)

No difficulty at all	1
A little difficulty	2
Moderate difficulty	3
Extreme difficulty	4
Stopped doing this because of your eyesight	5
Stopped doing this for other reasons or not interested in doing this	6

B6: How much difficulty do you have doing work or hobbies that require you to see well up close, such as cooking, sewing, fixing things around the house, or using hand tools? Would you say:

(Circle One)

No difficulty at all	1
A little difficulty	2
Moderate difficulty	3
Extreme difficulty	4
Stopped doing this because of your eyesight	5
Stopped doing this for other reasons or not interested in doing this	6

B7: Because of your eyesight, how much difficulty do you have finding something on a crowded shelf?

(Circle One)

No difficulty at all	1
A little difficulty	2
Moderate difficulty	3
Extreme difficulty	4
Stopped doing this because of your eyesight	5
Stopped doing this for other reasons or not interested in doing this	6

B8: How much difficulty do you have reading street signs or the names of stores?

(Circle One)

No difficulty at all	1
A little difficulty	2
Moderate difficulty	3
Extreme difficulty	4
Stopped doing this because of your eyesight	5
Stopped doing this for other reasons or not interested in doing this	6

B9: Because of your eyesight, how much difficulty do you have going down steps, stairs, or curbs in dim light or at night?

(Circle One)

No difficulty at all	1
A little difficulty	2
Moderate difficulty	3
Extreme difficulty	4
Stopped doing this because of your eyesight	5
Stopped doing this for other reasons or not interested in doing this	6

B10: Because of your eyesight, how much difficulty do you have noticing objects off to the side while you are walking along?

(Circle One)

No difficulty at all	1
A little difficulty	2
Moderate difficulty	3
Extreme difficulty	4
Stopped doing this because of your eyesight	5
Stopped doing this for other reasons or not interested in doing this	6

B11: Because of your eyesight, how much difficulty do you have seeing how people react to things you say?

(Circle One)

No difficulty at all	1
A little difficulty	2
Moderate difficulty	3
Extreme difficulty	4
Stopped doing this because of your eyesight	5
Stopped doing this for other reasons or not interested in doing this	6

B12: Because of your eyesight, how much difficulty do you have picking out and matching your own clothes?

(Circle One)

No difficulty at all	1
A little difficulty	2
Moderate difficulty	3
Extreme difficulty	4
Stopped doing this because of your eyesight	5
Stopped doing this for other reasons or not interested in doing this	6

B13: Because of your eyesight, how much difficulty do you have visiting with people in their homes, at parties, or in restaurants?

(Circle One)

No difficulty at all	1
A little difficulty	2
Moderate difficulty	3
Extreme difficulty	4
Stopped doing this because of your eyesight	5
Stopped doing this for other reasons or not interested in doing this	6

B14: Because of your eyesight, how much difficulty do you have going out to see movies, plays, or sports events?

(Circle One)

No difficulty at all	1
A little difficulty	2
Moderate difficulty	3
Extreme difficulty	4
Stopped doing this because of your eyesight	5
Stopped doing this for other reasons or not interested in doing this	6

B15: Are you currently driving, at least once in a while?

	(Circle One)	
Yes	1	*Skip To Question B15c (page 7)*
No	2	*Go to Question B15a*

B15a: If NO: Have you never driven a car or have you given up driving?

	(Circle One)	
Never drove	1	*Skip To Section B, Part 3, Question B17 (page 8)*
Gave up	2	*Go to Question B15b*

B15b: IF YOU GAVE UP DRIVING: Was that mainly because of your eyesight, mainly for some other reason, or because of both your eyesight and other reasons?

	(Circle One)	
Mainly eyesight	1	*Skip To Section B, Part 3, Question B17 (page 8)*
Mainly other reasons	2	*Skip To Section B, Part 3, Question B17 (page 8)*
Both eyesight and other reasons	3	*Skip To Section B, Part 3, Question B17 (page 8)*

B15c: IF CURRENTLY DRIVING: How much difficulty do you have driving during the daytime in familiar places? Would you say you have:

(Circle One)

No difficulty at all	1
A little difficulty	2
Moderate difficulty	3
Extreme difficulty	4

B16: How much difficulty do you have driving at night? Would you say you have:

(Circle One)

No difficulty at all	1
A little difficulty	2
Moderate difficulty	3
Extreme difficulty	4
Stopped doing this because of your eyesight	5
Stopped doing this for other reasons or not interested in doing this	6

B16a: How much difficulty do you have driving in difficult conditions, such as in bad weather, during rush hour, on the freeway, or in city traffic? Would you say you have:

(Circle One)

No difficulty at all	1
A little difficulty	2
Moderate difficulty	3
Extreme difficulty	4
Stopped doing this because of your eyesight	5
Stopped doing this for other reasons or not interested in doing this	6

SECTION B PART 3 – RESPONSES TO VISION PROBLEMS

The next questions are about how things you do may be affected by your vision. For each one, please circle the number to indicate whether for you the statement is true for you all, most, some, a little, or none of the time.

(Circle One On Each Line)

	All of the time	Most of the time	Some of the time	A little of the time	None of the time
B17: Do you accomplish less than you would like because of your vision?	*1*	*2*	*3*	*4*	*5*
B18: Are you limited in how long you can work or do other activities because of your vision?	*1*	*2*	*3*	*4*	*5*
B19: How much does pain or discomfort in or around your eyes, for example, burning, itching, or aching, keep you from doing what you'd like to be doing? Would you say:	*1*	*2*	*3*	*4*	*5*

For each of the following statements, please circle the number to indicate whether for you the statement is definitely true, mostly true, mostly false, or definitely false for you or you are not sure.

(Circle One On Each Line)

	Definitely True	Mostly True	Not Sure	Mostly False	Definitely False
B20: I stay home most of the time because of my eyesight.	*1*	*2*	*3*	*4*	*5*
B21: I feel frustrated a lot of the time because of my eyesight.	*1*	*2*	*3*	*4*	*5*
B22: I have much less control over what I do, because of my eyesight.	*1*	*2*	*3*	*4*	*5*
B23: Because of my eyesight, I have to rely too much on what other people tell me.	*1*	*2*	*3*	*4*	*5*
B24: I need a lot of help from others because of my eyesight.	*1*	*2*	*3*	*4*	*5*
B25: I worry about doing things that will embarrass myself or others, because of my eyesight.	*1*	*2*	*3*	*4*	*5*

SECTION C – DESCRIBING YOUR OWN HEALTH TODAY (EQ-5D)

The first section of the questionnaire is about your general health **today.**

By placing a **tick (✓)** in one box in each group below, please indicate which statements best describe your own health state **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 ☐

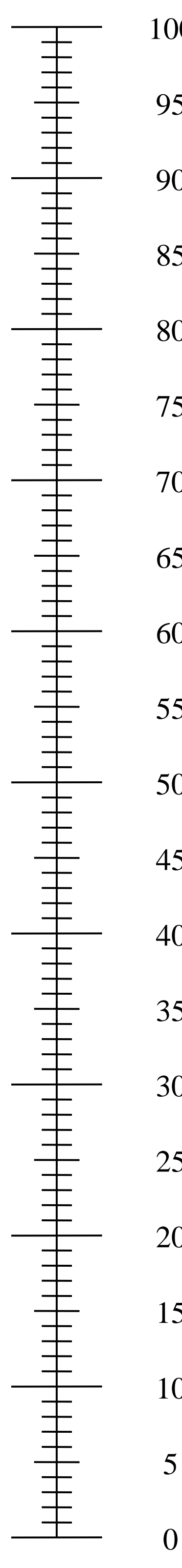
SELF-CARE
I have no problems washing or dressing myself ☐
I have slight problems washing or dressing myself ☐
I have moderate problems washing or dressing myself ☐
I have severe problems washing or dressing myself ☐
I am unable to wash or dress myself ☐

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 ☐

The best health
you can imagine



The worst health
you can imagine

- 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 =

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SECTION D - HEALTH UTILITY INDEX QUESTIONNAIRE (HUI3)

This set of questions asks about various aspects of your health. When answering these questions please think about your health and your ability to do things on a day-to-day basis, during the past week. Please select one answer that best describes your level of ability or disability during the past week. Please indicate the selected answer by circling the number (e.g. 1, 2, 3, etc.) beside the answer.

Vision:

1 Able to see well enough to read ordinary newsprint and recognize a friend on the other side of the street, without glasses or contact lenses.

2 Able to see well enough to read ordinary newsprint and recognize a friend on the other side of the street, but with glasses.

3 Able to read ordinary newsprint with or without glasses but unable to recognize a friend on the other side of the street, even with glasses.

4 Able to recognize a friend on the other side of the street with or without glasses but unable to read ordinary newsprint, even with glasses.

5 Unable to read ordinary newsprint and unable to recognize a friend on the other side of the street, even with glasses.

6 Unable to see at all.

Hearing:

1 Able to hear what is said in a group conversation with at least three other people, without a hearing aid.

2 Able to hear what is said in a conversation with one other person in a quiet room without a hearing aid, but requires a hearing aid to hear what is said in a group conversation with at least three other people.

3 Able to hear what is said in a conversation with one other person in a quiet room with a hearing aid, and able to hear what is said in a group conversation with at least three other people, with a hearing aid.

4 Able to hear what is said in a conversation with one other person in a quiet room, without a hearing aid, but unable to hear what is said in a group conversation with at least three other people even with a hearing aid.

5 Able to hear what is said in a conversation with one other person in a quiet room, with a hearing aid, but unable to hear what is said in a group conversation with at least three other people even with a hearing aid.

6 Unable to hear at all.

Speech:

1 Able to be understood completely when speaking with strangers or friends.

2 Able to be understood partially when speaking with strangers but able to be understood completely when speaking with people who know me well.

3 Able to be understood partially when speaking with strangers or people who know me well.

4 Unable to be understood when speaking with strangers but able to be understood partially by people who know me well.

5 Unable to be understood when speaking to other people (or unable to speak at all).

Ambulation:

1 Able to walk around the neighbourhood without difficulty, and without walking equipment

2 Able to walk around the neighbourhood with difficulty; but does not require walking equipment or the help of another person.

3 Able to walk around the neighbourhood with walking equipment, but without the help of another person

4 Able to walk only short distances with walking equipment, and requires a wheelchair to get around the neighbourhood.

5 Unable to walk alone, even with walking equipment. Able to walk short distances with the help of another person, and requires a wheelchair to get around the neighbourhood.

6 Cannot walk at all.

Dexterity:

1 Full use of two hands and ten fingers.

2 Limitations in the use of hands or fingers, but does not require special tools or help of another person.

3 Limitations in the use of hands or fingers, is independent with use of special tools (does not require the help of another person).

4 Limitations in the use of hands or fingers, requires the help of another person for some tasks (not independent even with use of special tools).

5 Limitations in use of hands or fingers, requires the help of another person for most tasks (not independent even with use of special tools).

6 Limitations in use of hands or fingers, requires the help of another person for all tasks (not independent even with use of special tools).

Emotion:	1	Happy and interested in life.
	2	Somewhat happy.
	3	Somewhat unhappy.
	4	Very unhappy.
	5	So unhappy that life is not worthwhile.

Cognition:	1	Able to remember most things, think clearly and solve day to day problems.
	2	Able to remember most things, but have a little difficulty when trying to think and solve day to day problems.
	3	Somewhat forgetful, but able to think clearly and solve day to day problems.
	4	Somewhat forgetful, and have a little difficulty when trying to think or solve day to day problems.
	5	Very forgetful, and have great difficulty when trying to think or solve day to day problems.
	6	Unable to remember anything at all, and unable to think or solve day to day problems.

Pain:	1	Free of pain and discomfort.
	2	Mild to moderate pain that prevents no activities.
	3	Moderate pain that prevents a few activities.
	4	Moderate to severe pain that prevents some activities.
	5	Severe pain that prevents most activities.

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*SECTION E – DESCRIBING YOUR EXPERIENCE OF GLAUCOMA^*

In this section of the questionnaire we are interested in the importance you place on the different characteristics of glaucoma and its treatment effects.

Some of these statements may seem similar to earlier questions in the booklet. However, they are an important measurement tool for valuing how glaucoma and its treatment affect you.

Please tick one box **(✓)**, for each of the **categories E1-E6**, which best describes any difficulties you have had in the **last month** with yourself, or your eyes or vision. **Remember,** if you wear glasses or contact lenses please answer all of the following questions as though you were wearing them.

As a guide about what is meant by the questions please look at the booklet **'Guide to the Questionnaire Sections'**.

E1: Central and near vision

For example, do you have any difficulties with reading, writing, watching TV, sewing, card games, computer work, reading dials on cookers on clocks or any activities similar to these?

No ☐
Some difficulty ☐
Quite a lot of difficulty ☐
Severe difficulty ☐

E2: Lighting and glare

For example, do you have any difficulties adjusting from light to dark and vice-versa), dazzle from bright lights, or difficulties seeing in dim light?

No ☐
Some difficulty ☐
Quite a lot of difficulty ☐
Severe difficulty ☐

E3: Mobility

For example, **because of your eyesight,** do you have any difficulties crossing roads, walking along busy pavements, negotiating steps and kerbs, tripping over low objects (for example children in pushchairs or dogs) or difficulties driving (or stopping driving) because of your vision?

No ☐
Some difficulty ☐
Quite a lot of difficulty ☐
Severe difficulty ☐

E4: Activities of daily living

For example, **because of your eyesight**, do you have any difficulties with domestic, DIY or self-care tasks around the home? This category includes difficulties pouring liquid into containers (e.g. water into a glass), problems judging shelf height leading to difficulties putting objects into or retrieving them from cupboards, being unaware of open cupboard doors and similar problems.

No ☐
Some difficulty ☐
Quite a lot of difficulty ☐
Severe difficulty ☐

E5: Eye discomfort

For example, any difficulties because of one or both eyes feeling gritty, sore, or tired?

No ☐
Some difficulty ☐
Quite a lot of difficulty ☐
Severe difficulty ☐

E6: Other possible effects of glaucoma or its treatment

For example, do you experience a dry mouth or a bitter after taste, fatigue, shortness of breath or difficulties with sexual functioning?

No ☐
Some difficulty ☐
Quite a lot of difficulty ☐
Severe difficulty ☐

^ Glaucoma Profile Index, GPI Burr JM, Kilonzo M, Vale L, Ryan M. Developing a Preference based Glaucoma Utility Index using a Discrete Choice Experiment. *Optom Vis Sci. 2007 Aug; 84(8):797-808*

Do you think your glaucoma is getting worse? **Yes** ☐

(Somner, 2012- IOVS) **No** ☐

Date you filled in this questionnaire D D / M M / Y Y Y Y

Have you asked for any help to fill this questionnaire today? **Yes** ☐

No ☐

THANK YOU

Thank you very much for your time and patience in filling in this questionnaire.

The information you have given us will be extremely useful in helping us carry out our research into treatments for Glaucoma.

It will be treated with the strictest confidence and kept securely.

Thank you again for your help.

If you would like any further information or have any queries about the study, please contact:

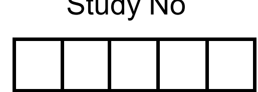
TAGS Study Office
Health Services Research Unit
University of Aberdeen
3rd Floor, Health Sciences Building
Foresterhill
Aberdeen
AB25 2ZD
UK

Telephone: 01224 438196
Email: tags@abdn.ac.uk
Website: www.tagsstudy.co.uk

The questionnaires are processed in Aberdeen at the Centre for Health Care Randomised Trials (CHaRT), Health Services Research Unit, Health Sciences Building, Foresterhill, Aberdeen, AB25 2ZD, UK.

1 MONTH QUESTIONNAIRE

Study No



TAGS

Treatment of Advanced Glaucoma Study

A multicentre randomised controlled trial comparing primary medical treatment with primary trabeculectomy for people with newly diagnosed advanced glaucoma

PARTICIPANT QUESTIONNAIRE

Thank you for helping us with our research.
We would be very grateful if you could complete this questionnaire.

CONFIDENTIAL

1 MONTH

ISRCTN - 56878850

Version 1.3 19 June 2015

TAGS is funded by the UK National Institute for Health Research (NIHR), Health Technology Assessment (HTA) Programme (12/35/38).

The following questionnaire is broken down into three sections (Section A - Section C as detailed below). Please work through all the sections as best you can from start to finish.

Some of the sections ask you to indicate your answers to the questions by placing a tick **(✓)** in the appropriate box, and other sections ask you to circle your answer out of a list that is provided. Please read the questions carefully and answer each one as accurately as you can.

If you have any difficulties reading the text or understanding the meaning of any questions, then please ask a TAGS member of staff or contact the central office in Aberdeen.

The sections covered in this questionnaire are as follows:

Section A: Describing your own health today

Section B: Health Utility Index

Section C: Describing your experience of Glaucoma

PLEASE TICK THE APPROPRIATE BOXES. Please remember that the answers from all TAGS questionnaires are strictly confidential.

Please try to complete all the questions. Some of the sections ask you to indicate your answers to the questions by placing a tick **(✓)** in the appropriate box, and other sections ask you to circle your answer out of a list that is provided. Please read the questions carefully and answer each one as accurately as you can.

INSTRUCTIONS:

1. In general we would like to have people try to complete these forms on their own. If you find that you need assistance, please feel free to ask the project staff and they will assist you.
2. Please answer every question (unless you are asked to skip questions because they don't apply to you).
3. Answer the questions by circling the appropriate number.
4. If you are unsure of how to answer a question, please give the best answer you can and make a comment in the left margin.
5. If you have any questions, please feel free to ask a member of the project staff, and they will be glad to help you.

STATEMENT OF CONFIDENTIALITY:

All information that would permit identification of any person who completed this questionnaire will be regarded as strictly confidential. Such information will be used only for the purposes of this study and will not be disclosed or released for any other purposes without prior consent, except as required by law.

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SECTION A – DESCRIBING YOUR OWN HEALTH TODAY (EQ-5D)

The first section of the questionnaire is about your general health **today.**

By placing a **tick (✓)** in one box in each group below, please indicate which statements best describe your own health state **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 ☐

The best health
you can imagine

- 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 =

100
95
90
85
80
75
70
65
60
55
50
45
40
35
30
25
20
15
10
5
0

The worst health
you can imagine

UK (English) v.2 © 2009 EuroQol Group. EQ-5D™ is a trade mark of the EuroQol Group

SECTION B – HEALTH UTILITY INDEX QUESTIONNAIRE (HUI3)

This set of questions asks about various aspects of your health. When answering these questions please think about your health and your ability to do things on a day-to-day basis, during the past week. Please select one answer that best describes your level of ability or disability during the past week. Please indicate the selected answer by circling the number (e.g. 1, 2, 3, etc.) beside the answer.

Vision:

1 Able to see well enough to read ordinary newsprint and recognize a friend on the other side of the street, without glasses or contact lenses.

2 Able to see well enough to read ordinary newsprint and recognize a friend on the other side of the street, but with glasses.

3 Able to read ordinary newsprint with or without glasses but unable to recognize a friend on the other side of the street, even with glasses.

4 Able to recognize a friend on the other side of the street with or without glasses but unable to read ordinary newsprint, even with glasses.

5 Unable to read ordinary newsprint and unable to recognize a friend on the other side of the street, even with glasses.

6 Unable to see at all.

Hearing:

1 Able to hear what is said in a group conversation with at least three other people, without a hearing aid.

2 Able to hear what is said in a conversation with one other person in a quiet room without a hearing aid, but requires a hearing aid to hear what is said in a group conversation with at least three other people.

3 Able to hear what is said in a conversation with one other person in a quiet room with a hearing aid, and able to hear what is said in a group conversation with at least three other people, with a hearing aid.

4 Able to hear what is said in a conversation with one other person in a quiet room, without a hearing aid, but unable to hear what is said in a group conversation with at least three other people even with a hearing aid.

5 Able to hear what is said in a conversation with one other person in a quiet room, with a hearing aid, but unable to hear what is said in a group conversation with at least three other people even with a hearing aid.

6 Unable to hear at all.

Speech:	1	Able to be understood completely when speaking with strangers or friends.
	2	Able to be understood partially when speaking with strangers but able to be understood completely when speaking with people who know me well.
	3	Able to be understood partially when speaking with strangers or people who know me well.
	4	Unable to be understood when speaking with strangers but able to be understood partially by people who know me well.
	5	Unable to be understood when speaking to other people (or unable to speak at all).

Ambulation:	1	Able to walk around the neighbourhood without difficulty, and without walking equipment
	2	Able to walk around the neighbourhood with difficulty; but does not require walking equipment or the help of another person.
	3	Able to walk around the neighbourhood with walking equipment, but without the help of another person
	4	Able to walk only short distances with walking equipment, and requires a wheelchair to get around the neighbourhood.
	5	Unable to walk alone, even with walking equipment. Able to walk short distances with the help of another person, and requires a wheelchair to get around the neighbourhood.
	6	Cannot walk at all.

Dexterity:	1	Full use of two hands and ten fingers.
	2	Limitations in the use of hands or fingers, but does not require special tools or help of another person.
	3	Limitations in the use of hands or fingers, is independent with use of special tools (does not require the help of another person).
	4	Limitations in the use of hands or fingers, requires the help of another person for some tasks (not independent even with use of special tools).
	5	Limitations in use of hands or fingers, requires the help of another person for most tasks (not independent even with use of special tools).
	6	Limitations in use of hands or fingers, requires the help of another person for all tasks (not independent even with use of special tools).

Emotion:

1 Happy and interested in life.

2 Somewhat happy.

3 Somewhat unhappy.

4 Very unhappy.

5 So unhappy that life is not worthwhile.

Cognition:

1 Able to remember most things, think clearly and solve day to day problems.

2 Able to remember most things, but have a little difficulty when trying to think and solve day to day problems.

3 Somewhat forgetful, but able to think clearly and solve day to day problems.

4 Somewhat forgetful, and have a little difficulty when trying to think or solve day to day problems.

5 Very forgetful, and have great difficulty when trying to think or solve day to day problems.

6 Unable to remember anything at all, and unable to think or solve day to day problems.

Pain:

1 Free of pain and discomfort.

2 Mild to moderate pain that prevents no activities.

3 Moderate pain that prevents a few activities.

4 Moderate to severe pain that prevents some activities.

5 Severe pain that prevents most activities.

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*SECTION C – DESCRIBING YOUR EXPERIENCE OF GLAUCOMA^*

In this section of the questionnaire we are interested in the importance you place on the different characteristics of glaucoma and its treatment effects.

Some of these statements may seem similar to earlier questions in the booklet. However, they are an important measurement tool for valuing how glaucoma and its treatment affect you.

Please tick one box **(✓)**, for each of the **categories 1-6**, which best describes any difficulties you have had in the **last month** with yourself, or your eyes or vision. **Remember,** if you wear glasses or contact lenses please answer all of the following questions as though you were wearing them.

As a guide about what is meant by the questions please look at the booklet **'Guide to the Questionnaire Sections'**.

C1: Central and near vision

For example, do you have any difficulties with reading, writing, watching TV, sewing, card games, computer work, reading dials on cookers on clocks or any activities similar to these?

No ☐
Some difficulty ☐
Quite a lot of difficulty ☐
Severe difficulty ☐

C2: Lighting and glare

For example, do you have any difficulties adjusting from light to dark and vice-versa), dazzle from bright lights, or difficulties seeing in dim light?

No ☐
Some difficulty ☐
Quite a lot of difficulty ☐
Severe difficulty ☐

C3: Mobility

For example, **because of your eyesight,** do you have any difficulties crossing roads, walking along busy pavements, negotiating steps and kerbs, tripping over low objects (for example children in pushchairs or dogs) or difficulties driving (or stopping driving) because of your vision?

No ☐
Some difficulty ☐
Quite a lot of difficulty ☐
Severe difficulty ☐

C4: Activities of daily living

For example, **because of your eyesight**, do you have any difficulties with domestic, DIY or self-care tasks around the home? This category includes difficulties pouring liquid into containers (e.g. water into a glass), problems judging shelf height leading to difficulties putting objects into or retrieving them from cupboards, being unaware of open cupboard doors and similar problems.

No ☐
Some difficulty ☐
Quite a lot of difficulty ☐
Severe difficulty ☐

C5: Eye discomfort

For example, have any difficulties because of one or both eyes feeling gritty, sore, or tired?

No ☐
Some difficulty ☐
Quite a lot of difficulty ☐
Severe difficulty ☐

C6: Other possible effects of glaucoma or its treatment

For example, do you experience a dry mouth or a bitter after taste, fatigue, shortness of breath or difficulties with sexual functioning?

No ☐
Some difficulty ☐
Quite a lot of difficulty ☐
Severe difficulty ☐

^ Glaucoma Profile Index, GPI Burr JM, Kilonzo M, Vale L, Ryan M. Developing a Preference based Glaucoma Utility Index using a Discrete Choice Experiment. *Optom Vis Sci. 2007 Aug; 84(8):797-808*

Do you think your glaucoma is getting worse? **Yes** ☐

(Somner, 2012- IOVS) **No** ☐

Date you filled in this questionnaire D D / M M / Y Y Y Y

Have you asked for any help to fill this questionnaire today? **Yes** ☐

No ☐

THANK YOU

Thank you very much for your time and patience in filling in this questionnaire.

The information you have given us will be extremely useful in helping us carry out our research into treatments for Glaucoma.

It will be treated with the strictest confidence and kept securely.

Thank you again for your help

If you would like any further information or have any queries about the study, please contact:

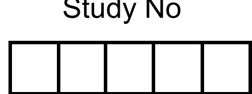
TAGS Study Office
Health Services Research Unit
University of Aberdeen
3rd Floor, Health Sciences Building
Foresterhill
Aberdeen
AB25 2ZD
UK

Telephone: 01224 438196
Email: tags@abdn.ac.uk
Website: www.tagsstudy.co.uk

The questionnaires are processed in Aberdeen at the
Centre for Health Care Randomised Trials (CHaRT), Health Services Research Unit,
Health Sciences Building, Foresterhill, Aberdeen, AB25 2ZD, UK.

PRE-TRABECULECTOMY QUESTIONNAIRE

Study No



TAGS

Treatment of Advanced Glaucoma Study

A multicentre randomised controlled trial comparing primary medical treatment with primary trabeculectomy for people with newly diagnosed advanced glaucoma.

PARTICIPANT QUESTIONNAIRE

Thank you for helping us with our research.
We would be very grateful if you could complete this questionnaire.

CONFIDENTIAL

PRE-TRABECULECTOMY

ISRCTN - 56878850

Version 1.3 19 June 2015

TAGS is funded by the UK National Institute for Health Research (NIHR), Health Technology Assessment (HTA) Programme (12/35/38).

The following questionnaire is broken down into three sections (Section A - Section C as detailed below). Please work through all the sections as best you can from start to finish.

Some of the sections ask you to indicate your answers to the questions by placing a tick **(✓)** in the appropriate box, and other sections ask you to circle your answer out of a list that is provided. Please read the questions carefully and answer each one as accurately as you can.

If you have any difficulties reading the text or understanding the meaning of any questions, then please ask a TAGS member of staff or contact the central office in Aberdeen.

The sections covered in this questionnaire are as follows:

Section A: Describing your own health today

Section B: Health Utility Index

Section C: Describing your experience of Glaucoma

PLEASE TICK THE APPROPRIATE BOXES. Please remember that the answers from all TAGS questionnaires are strictly confidential.

Please try to complete all the questions. Some of the sections ask you to indicate your answers to the questions by placing a tick **(✓)** in the appropriate box, and other sections ask you to circle your answer out of a list that is provided. Please read the questions carefully and answer each one as accurately as you can.

INSTRUCTIONS:

1. In general we would like to have people try to complete these forms on their own. If you find that you need assistance, please feel free to ask the project staff and they will assist you.
2. Please answer every question (unless you are asked to skip questions because they don't apply to you).
3. Answer the questions by circling the appropriate number.
4. If you are unsure of how to answer a question, please give the best answer you can and make a comment in the left margin.
5. If you have any questions, please feel free to ask a member of the project staff, and they will be glad to help you.

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SECTION A – DESCRIBING YOUR OWN HEALTH TODAY (EQ-5D)

The first section of the questionnaire is about your general health **today.**

By placing a **tick (✓)** in one box in each group below, please indicate which statements best describe your own health state **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 = ☐

The best health you can imagine

100
95
90
85
80
75
70
65
60
55
50
45
40
35
30
25
20
15
10
5
0

The worst health you can imagine

UK (English) v.2 © 2009 EuroQol Group. EQ-5D™ is a trade mark of the EuroQol Group

SECTION B – HEALTH UTILITY INDEX QUESTIONNAIRE (HUI3)

This set of questions asks about various aspects of your health. When answering these questions please think about your health and your ability to do things on a day-to-day basis, during the past week. Please select one answer that best describes your level of ability or disability during the past week. Please indicate the selected answer by circling the number (e.g. 1, 2, 3, etc.) beside the answer.

Vision:

1 Able to see well enough to read ordinary newsprint and recognize a friend on the other side of the street, without glasses or contact lenses.

2 Able to see well enough to read ordinary newsprint and recognize a friend on the other side of the street, but with glasses.

3 Able to read ordinary newsprint with or without glasses but unable to recognize a friend on the other side of the street, even with glasses.

4 Able to recognize a friend on the other side of the street with or without glasses but unable to read ordinary newsprint, even with glasses.

5 Unable to read ordinary newsprint and unable to recognize a friend on the other side of the street, even with glasses.

6 Unable to see at all.

Hearing:

1 Able to hear what is said in a group conversation with at least three other people, without a hearing aid.

2 Able to hear what is said in a conversation with one other person in a quiet room without a hearing aid, but requires a hearing aid to hear what is said in a group conversation with at least three other people.

3 Able to hear what is said in a conversation with one other person in a quiet room with a hearing aid, and able to hear what is said in a group conversation with at least three other people, with a hearing aid.

4 Able to hear what is said in a conversation with one other person in a quiet room, without a hearing aid, but unable to hear what is said in a group conversation with at least three other people even with a hearing aid.

5 Able to hear what is said in a conversation with one other person in a quiet room, with a hearing aid, but unable to hear what is said in a group conversation with at least three other people even with a hearing aid.

6 Unable to hear at all.

Speech:

1 Able to be understood completely when speaking with strangers or friends.

2 Able to be understood partially when speaking with strangers but able to be understood completely when speaking with people who know me well.

3 Able to be understood partially when speaking with strangers or people who know me well.

4 Unable to be understood when speaking with strangers but able to be understood partially by people who know me well.

5 Unable to be understood when speaking to other people (or unable to speak at all).

Ambulation:

1 Able to walk around the neighbourhood without difficulty, and without walking equipment

2 Able to walk around the neighbourhood with difficulty; but does not require walking equipment or the help of another person.

3 Able to walk around the neighbourhood with walking equipment, but without the help of another person

4 Able to walk only short distances with walking equipment, and requires a wheelchair to get around the neighbourhood.

5 Unable to walk alone, even with walking equipment. Able to walk short distances with the help of another person, and requires a wheelchair to get around the neighbourhood.

6 Cannot walk at all.

Dexterity:

1 Full use of two hands and ten fingers.

2 Limitations in the use of hands or fingers, but does not require special tools or help of another person.

3 Limitations in the use of hands or fingers, is independent with use of special tools (does not require the help of another person).

4 Limitations in the use of hands or fingers, requires the help of another person for some tasks (not independent even with use of special tools).

5 Limitations in use of hands or fingers, requires the help of another person for most tasks (not independent even with use of special tools).

6 Limitations in use of hands or fingers, requires the help of another person for all tasks (not independent even with use of special tools).

Emotion:

1 Happy and interested in life.

2 Somewhat happy.

3 Somewhat unhappy.

4 Very unhappy.

5 So unhappy that life is not worthwhile.

Cognition:

1 Able to remember most things, think clearly and solve day to day problems.

2 Able to remember most things, but have a little difficulty when trying to think and solve day to day problems.

3 Somewhat forgetful, but able to think clearly and solve day to day problems.

4 Somewhat forgetful, and have a little difficulty when trying to think or solve day to day problems.

5 Very forgetful, and have great difficulty when trying to think or solve day to day problems.

6 Unable to remember anything at all, and unable to think or solve day to day problems.

Pain:

1 Free of pain and discomfort.

2 Mild to moderate pain that prevents no activities.

3 Moderate pain that prevents a few activities.

4 Moderate to severe pain that prevents some activities.

5 Severe pain that prevents most activities.

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*SECTION C – DESCRIBING YOUR EXPERIENCE OF GLAUCOMA^*

In this section of the questionnaire we are interested in the importance you place on the different characteristics of glaucoma and its treatment effects.

Some of these statements may seem similar to earlier questions in the booklet. However, they are an important measurement tool for valuing how glaucoma and its treatment affect you.

Please tick one box **(✓)**, for each of the **categories 1-6**, which best describes any difficulties you have had in the **last month** with yourself, or your eyes or vision. **Remember,** if you wear glasses or contact lenses please answer all of the following questions as though you were wearing them.

As a guide about what is meant by the questions please look at the booklet **'Guide to the Questionnaire Sections'**.

C1: Central and near vision

For example, do you have any difficulties with reading, writing, watching TV, sewing, card games, computer work, reading dials on cookers on clocks or any activities similar to these?

No ☐
Some difficulty ☐
Quite a lot of difficulty ☐
Severe difficulty ☐

C2: Lighting and glare

For example, do you have any difficulties adjusting from light to dark and vice-versa), dazzle from bright lights, or difficulties seeing in dim light?

No ☐
Some difficulty ☐
Quite a lot of difficulty ☐
Severe difficulty ☐

C3: Mobility

For example, **because of your eyesight,** do you have any difficulties crossing roads, walking along busy pavements, negotiating steps and kerbs, tripping over low objects (for example children in pushchairs or dogs) or difficulties driving (or stopping driving) because of your vision?

No ☐
Some difficulty ☐
Quite a lot of difficulty ☐
Severe difficulty ☐

C4: Activities of daily living

For example, **because of your eyesight**, do you have any difficulties with domestic, DIY or self-care tasks around the home? This category includes difficulties pouring liquid into containers (e.g. water into a glass), problems judging shelf height leading to difficulties putting objects into or retrieving them from cupboards, being unaware of open cupboard doors and similar problems.

No ☐
Some difficulty ☐
Quite a lot of difficulty ☐
Severe difficulty ☐

C5: Eye discomfort

For example, have any difficulties because of one or both eyes feeling gritty, sore, or tired?

No ☐
Some difficulty ☐
Quite a lot of difficulty ☐
Severe difficulty ☐

C6: Other possible effects of glaucoma or its treatment

For example, do you experience a dry mouth or a bitter after taste, fatigue, shortness of breath or difficulties with sexual functioning?

No ☐
Some difficulty ☐
Quite a lot of difficulty ☐
Severe difficulty ☐

^ Glaucoma Profile Index, GPI Burr JM, Kilonzo M, Vale L, Ryan M. Developing a Preference based Glaucoma Utility Index using a Discrete Choice Experiment. *Optom Vis Sci. 2007 Aug; 84(8):797-808*

Do you think your glaucoma is getting worse? **Yes** ☐

(Somner, 2012- IOVS) **No** ☐

Date you filled in this questionnaire D D / M M / Y Y Y Y

Have you asked for any help to fill this questionnaire today? **Yes** ☐

No ☐

THANK YOU

Thank you very much for your time and patience in filling in this questionnaire.

The information you have given us will be extremely useful in helping us carry out our research into treatments for Glaucoma.

It will be treated with the strictest confidence and kept securely.

Thank you again for your help

If you would like any further information or have any queries about the study, please contact:

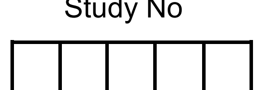
TAGS Study Office
Health Services Research Unit
University of Aberdeen
3rd Floor, Health Sciences Building
Foresterhill
Aberdeen
AB25 2ZD
UK

Telephone: 01224 438196
Email: tags@abdn.ac.uk
Website: www.tagsstudy.co.uk

The questionnaires are processed in Aberdeen at the
Centre for Health Care Randomised Trials (CHaRT), Health Services Research Unit,
Health Sciences Building, Foresterhill, Aberdeen, AB25 2ZD, UK.

4 MONTH QUESTIONNAIRE

Study No



TAGS

Treatment of Advanced Glaucoma Study

A multicentre randomised controlled trial comparing primary medical treatment with primary trabeculectomy for people with newly diagnosed advanced glaucoma.

PARTICIPANT QUESTIONNAIRE

Thank you for helping us with our research.
We would be very grateful if you could complete this questionnaire.

CONFIDENTIAL

4 MONTH

ISRCTN - 56878850

Version 1.2 19 June 2015

TAGS is funded by the UK National Institute for Health Research (NIHR), Health Technology Assessment (HTA) Programme (12/35/38).

The following questionnaire is broken down into two sections (Section A and Section B as detailed below). Please work through all the sections as best you can from start to finish.

Some of the sections ask you to indicate your answers to the questions by placing a tick **(✓)** in the appropriate box, and other sections ask you to circle your answer out of a list that is provided. Please read the questions carefully and answer each one as accurately as you can.

If you have any difficulties reading the text or understanding the meaning of any questions, then please ask a TAGS member of staff or contact the central office in Aberdeen.

The sections covered in this questionnaire are as follows:

Section A: Visual Functioning Questionnaire (split into 3 parts):

Part 1 - General Health and Vision

Part 2 - Difficulty with activities

Part 3 - Response to vision problems

Section B: Health Care Utilisation

Please try to complete all the questions. Some of the sections ask you to indicate your answers to the questions by placing a tick **(✓)** in the appropriate box, and other sections ask you to circle your answer out of a list that is provided. Please read the questions carefully and answer each one as accurately as you can.

SECTION A – VISUAL FUNCTIONING QUESTIONNAIRE (NEI-VFQ-25)

The following section is a survey with statements about problems, which involve your vision, or feelings that you have about your eye condition. After each question please choose the response that best describes your situation. Please take as much time as you need to answer each question. All your answers are confidential. In order for this survey to improve our knowledge about eye problems and how they affect your quality of life, your answers must be as accurate as possible. Remember, if you wear glasses or contact lenses, please answer all of the following questions as though you were wearing them.

INSTRUCTIONS:

1. In general we would like to have people try to complete these forms on their own. If you find that you need assistance, please feel free to ask the project staff and they will assist you.
2. Please answer every question (unless you are asked to skip questions because they don’t apply to you).
3. Answer the questions by circling the appropriate number.
4. If you are unsure of how to answer a question, please give the best answer you can and make a comment in the left margin.
5. If you have any questions, please feel free to ask a member of the project staff, and they will be glad to help you.

STATEMENT OF CONFIDENTIALITY:

All information that would permit identification of any person who completed this questionnaire will be regarded as strictly confidential. Such information will be used only for the purposes of this study and will not be disclosed or released for any other purposes without prior consent, except as required by law.

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SECTION A – PART 1 GENERAL HEALTH AND VISION (NEI-VFQ-25)

A1: In general, would you say your overall health is:

(Circle One)

Excellent	1
Very Good	2
Good	3
Fair	4
Poor	5

A2: At the present time, would you say your eyesight using both eyes (with glasses or contact lenses, if you wear them) is excellent, good, fair, poor, or very poor or are you completely blind?

(Circle One)

Excellent	1
Good	2
Fair	3
Poor	4
Very Poor	5
Completely Blind	6

A3: How much of the time do you worry about your eyesight?

(Circle One)

None of the time	1
A little of the time	2
Some of the time	3
Most of the time	4
All of the time	5

A4: How much pain or discomfort have you had in and around your eyes (for example, burning, itching, or aching)? Would you say it is:

(Circle One)

None	1
Mild	2
Moderate	3
Severe, or	4
Very severe	5

SECTION A - PART 2 DIFFICULTY WITH ACTIVITIES

The next questions are about how much difficulty, if any, you have doing certain activities wearing your glasses or contact lenses if you use them for that activity.

A5: How much difficulty do you have reading ordinary print in newspapers? Would you say you have:

(Circle One)

No difficulty at all	1
A little difficulty	2
Moderate difficulty	3
Extreme difficulty	4
Stopped doing this because of your eyesight	5
Stopped doing this for other reasons or not interested in doing this	6

A6: How much difficulty do you have doing work or hobbies that require you to see well up close, such as cooking, sewing, fixing things around the house, or using hand tools? Would you say:

(Circle One)

No difficulty at all	1
A little difficulty	2
Moderate difficulty	3
Extreme difficulty	4
Stopped doing this because of your eyesight	5
Stopped doing this for other reasons or not interested in doing this	6

A7: Because of your eyesight, how much difficulty do you have finding something on a crowded shelf?

(Circle One)

No difficulty at all	1
A little difficulty	2
Moderate difficulty	3
Extreme difficulty	4
Stopped doing this because of your eyesight	5
Stopped doing this for other reasons or not interested in doing this	6

A8: How much difficulty do you have reading street signs or the names of stores?

(Circle One)

No difficulty at all	1
A little difficulty	2
Moderate difficulty	3
Extreme difficulty	4
Stopped doing this because of your eyesight	5
Stopped doing this for other reasons or not interested in doing this	6

A9: Because of your eyesight, how much difficulty do you have going down steps, stairs, or curbs in dim light or at night?

(Circle One)

No difficulty at all	1
A little difficulty	2
Moderate difficulty	3
Extreme difficulty	4
Stopped doing this because of your eyesight	5
Stopped doing this for other reasons or not interested in doing this	6

A10: Because of your eyesight, how much difficulty do you have noticing objects off to the side while you are walking along?

(Circle One)

No difficulty at all	1
A little difficulty	2
Moderate difficulty	3
Extreme difficulty	4
Stopped doing this because of your eyesight	5
Stopped doing this for other reasons or not interested in doing this	6

A11: Because of your eyesight, how much difficulty do you have seeing how people react to things you say?

(Circle One)

No difficulty at all	1
A little difficulty	2
Moderate difficulty	3
Extreme difficulty	4
Stopped doing this because of your eyesight	5
Stopped doing this for other reasons or not interested in doing this	6

A12: Because of your eyesight, how much difficulty do you have picking out and matching your own clothes?

(Circle One)

No difficulty at all	1
A little difficulty	2
Moderate difficulty	3
Extreme difficulty	4
Stopped doing this because of your eyesight	5
Stopped doing this for other reasons or not interested in doing this	6

A13: Because of your eyesight, how much difficulty do you have visiting with people in their homes, at parties, or in restaurants?

(Circle One)

No difficulty at all	1
A little difficulty	2
Moderate difficulty	3
Extreme difficulty	4
Stopped doing this because of your eyesight	5
Stopped doing this for other reasons or not interested in doing this	6

A14: Because of your eyesight, how much difficulty do you have going out to see movies, plays, or sports events?

(Circle One)

No difficulty at all	1
A little difficulty	2
Moderate difficulty	3
Extreme difficulty	4
Stopped doing this because of your eyesight	5
Stopped doing this for other reasons or not interested in doing this	6

A15: Are you currently driving, at least once in a while?

	(Circle One)	
Yes	1	*Skip To Question A15c (page 6)*
No	2	*Go to Question 15a*

A15a: If NO: Have you never driven a car or have you given up driving?

	(Circle One)	
Never drove	1	*Skip To Section A, Part 3, Question A17 (page 7)*
Gave up	2	*Go to Question 15b*

A15b: IF YOU GAVE UP DRIVING: Was that mainly because of your eyesight, mainly for some other reason, or because of both your eyesight and other reasons?

	(Circle One)	
Mainly eyesight	1	*Skip To Section A, Part 3, Question A17 (page 7)*
Mainly other reasons	2	*Skip To Section A, Part 3, Question A17 (page 7)*
Both eyesight and other reasons	3	*Skip To Section A, Part 3, Question A17 (page 7)*

A15c: IF CURRENTLY DRIVING: How much difficulty do you have driving during the daytime in familiar places? Would you say you have:

(Circle One)

No difficulty at all	1
A little difficulty	2
Moderate difficulty	3
Extreme difficulty	4

A16: How much difficulty do you have driving at night? Would you say you have:

(Circle One)

No difficulty at all	1
A little difficulty	2
Moderate difficulty	3
Extreme difficulty	4
Stopped doing this because of your eyesight	5
Stopped doing this for other reasons or not interested in doing this	6

A16a: How much difficulty do you have driving in difficult conditions, such as in bad weather, during rush hour, on the freeway, or in city traffic? Would you say you have:

(Circle One)

No difficulty at all	1
A little difficulty	2
Moderate difficulty	3
Extreme difficulty	4
Stopped doing this because of your eyesight	5
Stopped doing this for other reasons or not interested in doing this	6

SECTION A PART 3 – RESPONSES TO VISION PROBLEMS

The next questions are about how things you do may be affected by your vision. For each one, please circle the number to indicate whether for you the statement is true for you all, most, some, a little, or none of the time.

(Circle One On Each Line)

	All of the time	Most of the time	Some of the time	A little of the time	None of the time
A17: Do you accomplish less than you would like because of your vision?	*1*	*2*	*3*	*4*	*5*
A18: Are you limited in how long you can work or do other activities because of your vision?	*1*	*2*	*3*	*4*	*5*
A19: How much does pain or discomfort in or around your eyes, for example, burning, itching, or aching, keep you from doing what you'd like to be doing? Would you say:	*1*	*2*	*3*	*4*	*5*

For each of the following statements, please circle the number to indicate whether for you the statement is definitely true, mostly true, mostly false, or definitely false for you or you are not sure.

(Circle One On Each Line)

	Definitely True	Mostly True	Not Sure	Mostly False	Definitely False
A20: I stay home most of the time because of my eyesight.	*1*	*2*	*3*	*4*	*5*
A21: I feel frustrated a lot of the time because of my eyesight.	*1*	*2*	*3*	*4*	*5*
A22: I have much less control over what I do, because of my eyesight.	*1*	*2*	*3*	*4*	*5*
A23: Because of my eyesight, I have to rely too much on what other people tell me.	*1*	*2*	*3*	*4*	*5*
A24: I need a lot of help from others because of my eyesight.	*1*	*2*	*3*	*4*	*5*
A25: I worry about doing things that will embarrass myself or others, because of my eyesight.	*1*	*2*	*3*	*4*	*5*

SECTION B – HEALTH CARE UTILISATION

Please print carefully within the boxes like this | 2 | 7 | **or like this** ✓

B1: Have you been to see a GP because of your eyes during the last 4 months?

Yes ☐

No ☐

If Yes, please give details:

B2: How many appointments did you attend with a GP? (at GP surgery) ☐☐

B3: How many times did a GP visit you at home? ☐☐

B4: How many times did you have a telephone conversation with a GP? ☐☐

B5: Have you had any appointments with a community optician or optometrist in the last 4 months?

Yes (Go to B6) ☐

No (Skip to B7) ☐

B6: How many appointments with a community optician or optometrist did you attend? ☐☐

B7: During the last 4 months have you had new spectacles or contact lenses?

Yes ☐

No ☐

B7a: If Yes (to B7 above), how much did you pay? £

This next question is about any appointments you may have had with other health care workers in the past 4 months

B8: During the last 4 months have you had an appointment with:

A District Nurse? Yes ☐ No ☐ If Yes, how many appointments did you have? ☐☐

A Practice Nurse? Yes ☐ No ☐ If Yes, how many appointments did you have? ☐☐

Other? Please specify Yes ☐ No ☐

________________________ How many appointments did you have? ☐☐

________________________ How many appointments did you have? ☐☐

This set of questions is about any private health care you may have had in the past 4 months

B9: During the last 4 months have you paid for any private health care? Yes ☐ No ☐

If Yes please go to B9a, then B9b (below) if no please skip to B10

B9a: If Yes, what sort of care did you pay for? ________________________

B9b: If Yes, how much did it cost? £

B10: During the last 4 months have you had any days off work or your usual activities because of your eyes? Yes ☐ No ☐ If Yes; how many days? ☐☐

B11: During the last 4 months, have you utilised any information or services related to your sensory impairment?

Yes ☐
No ☐

e.g. Low Vision Clinic, ☐

Services offered by the Royal National Institute of Blind People, etc. ☐

If another, could you please specify in the space provided:

B12: Are you currently in receipt of any form of travel allowance/concession as a result of your sensory impairment?

Yes ☐
No ☐

e.g. Disabled person's railcard ☐ **Dial-a-ride** ☐

Companion's permit ☐

If another, could you please specify in the space provided:

B13: Are you currently in receipt of any welfare benefits as a result of your sensory impairment?

Yes ☐
No ☐

e.g. Disability living allowance ☐ **Incapacity benefit** ☐

Carer's allowance ☐

If another, could you please specify in the space provided:

Date you filled in this questionnaire D D / M M / Y Y Y Y

Have you asked for any help to fill this questionnaire today?

Yes ☐

No ☐

THANK YOU

Thank you very much for your time and patience in filling in this questionnaire.

The information you have given us will be extremely useful in helping us carry out our research into treatments for Glaucoma.

It will be treated with the strictest confidence and kept securely.

Thank you again for your help

If you would like any further information or have any queries about the study, please contact:

TAGS Study Office
Health Services Research Unit
University of Aberdeen
3rd Floor, Health Sciences Building
Foresterhill
Aberdeen
AB25 2ZD
UK

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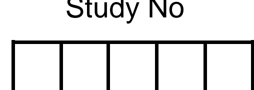
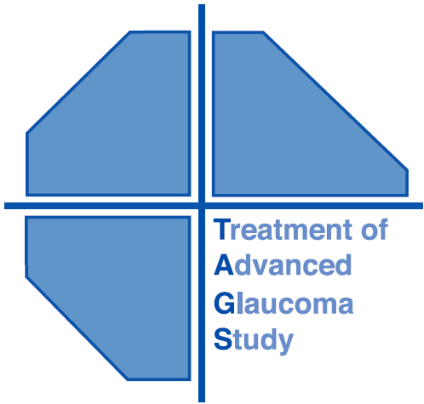
The questionnaires are processed in Aberdeen at the
Centre for Health Care Randomised Trials (CHaRT), Health Services Research Unit,
Health Sciences Building, Foresterhill, Aberdeen, AB25 2ZD, UK.

12 MONTH QUESTIONNAIRE

Study No





TAGS

Treatment of Advanced Glaucoma Study

A multicentre randomised controlled trial comparing primary medical treatment with primary trabeculectomy for people with newly diagnosed advanced glaucoma.

PARTICIPANT QUESTIONNAIRE

Thank you for helping us with our research.
We would be very grateful if you could complete this questionnaire.

CONFIDENTIAL

12 MONTHS

The following questionnaire is broken down into four sections (Section A - Section D as detailed below). Please work through all the sections as best you can from start to finish.

Some of the sections ask you to indicate your answers to the questions by placing a tick **(✓)** in the appropriate box, and other sections ask you to circle your answer out of a list that is provided. Please read the questions carefully and answer each one as accurately as you can.

If you have any difficulties reading the text or understanding the meaning of any questions, then please ask a TAGS member of staff or contact the central office in Aberdeen.

The sections covered in this questionnaire are as follows:

Section A: Visual Functioning Questionnaire (split into 3 parts)

Part 1 - General Health and Vision

Part 2 - Difficulty with activities

Part 3 - Response to vision problems

Section B: Describing your own health today

Section C: Health Utility Index

Section D: Describing your experience of Glaucoma

Section E: Health Care Utilisation

Please try to complete all the questions. Some of the sections ask you to indicate your answers to the questions by placing a tick **(✓)** in the appropriate box, and other sections ask you to circle your answer out of a list that is provided. Please read the questions carefully and answer each one as accurately as you can.

SECTION A – VISUAL FUNCTIONING QUESTIONNAIRE (NEI-VFQ-25)

The following section is a survey with statements about problems, which involve your vision, or feelings that you have about your eye condition. After each question please choose the response that best describes your situation. Please take as much time as you need to answer each question. All your answers are confidential. In order for this survey to improve our knowledge about eye problems and how they affect your quality of life, your answers must be as accurate as possible. Remember, if you wear glasses or contact lenses, please answer all of the following questions as though you were wearing them.

INSTRUCTIONS:

1. In general we would like to have people try to complete these forms on their own. If you find that you need assistance, please feel free to ask the project staff and they will assist you.
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© R **1996**

SECTION A – PART 1 GENERAL HEALTH AND VISION (NEI-VFQ-25)

A1: In general, would you say your overall health is:

(Circle One)

Excellent	1
Very Good	2
Good	3
Fair	4
Poor	5

A2: At the present time, would you say your eyesight using both eyes (with glasses or contact lenses, if you wear them) is excellent, good, fair, poor, or very poor or are you completely blind?

(Circle One)

Excellent	1
Good	2
Fair	3
Poor	4
Very Poor	5
Completely Blind	6

A3: How much of the time do you worry about your eyesight?

(Circle One)

None of the time	1
A little of the time	2
Some of the time	3
Most of the time	4
All of the time	5

A4: How much pain or discomfort have you had in and around your eyes (for example, burning, itching, or aching)? Would you say it is:

(Circle One)

None	1
Mild	2
Moderate	3
Severe, or	4
Very severe	5

SECTION A - PART 2 DIFFICULTY WITH ACTIVITIES

The next questions are about how much difficulty, if any, you have doing certain activities wearing your glasses or contact lenses if you use them for that activity.

A5: How much difficulty do you have reading ordinary print in newspapers? Would you say you have:

(Circle One)

No difficulty at all	1
A little difficulty	2
Moderate difficulty	3
Extreme difficulty	4
Stopped doing this because of your eyesight	5
Stopped doing this for other reasons or not interested in doing this	6

A6: How much difficulty do you have doing work or hobbies that require you to see well up close, such as cooking, sewing, fixing things around the house, or using hand tools? Would you say:

(Circle One)

No difficulty at all	1
A little difficulty	2
Moderate difficulty	3
Extreme difficulty	4
Stopped doing this because of your eyesight	5
Stopped doing this for other reasons or not interested in doing this	6

A7: Because of your eyesight, how much difficulty do you have finding something on a crowded shelf?

(Circle One)

No difficulty at all	1
A little difficulty	2
Moderate difficulty	3
Extreme difficulty	4
Stopped doing this because of your eyesight	5
Stopped doing this for other reasons or not interested in doing this	6

A8: How much difficulty do you have reading street signs or the names of stores?

(Circle One)

No difficulty at all	1
A little difficulty	2
Moderate difficulty	3
Extreme difficulty	4
Stopped doing this because of your eyesight	5
Stopped doing this for other reasons or not interested in doing this	6

A9: Because of your eyesight, how much difficulty do you have going down steps, stairs, or curbs in dim light or at night?

(Circle One)

No difficulty at all	1
A little difficulty	2
Moderate difficulty	3
Extreme difficulty	4
Stopped doing this because of your eyesight	5
Stopped doing this for other reasons or not interested in doing this	6

A10: Because of your eyesight, how much difficulty do you have noticing objects off to the side while you are walking along?

(Circle One)

No difficulty at all	1
A little difficulty	2
Moderate difficulty	3
Extreme difficulty	4
Stopped doing this because of your eyesight	5
Stopped doing this for other reasons or not interested in doing this	6

A11: Because of your eyesight, how much difficulty do you have seeing how people react to things you say?

(Circle One)

No difficulty at all	1
A little difficulty	2
Moderate difficulty	3
Extreme difficulty	4
Stopped doing this because of your eyesight	5
Stopped doing this for other reasons or not interested in doing this	6

A12: Because of your eyesight, how much difficulty do you have picking out and matching your own clothes?

(Circle One)

No difficulty at all	1
A little difficulty	2
Moderate difficulty	3
Extreme difficulty	4
Stopped doing this because of your eyesight	5
Stopped doing this for other reasons or not interested in doing this	6

A13: Because of your eyesight, how much difficulty do you have visiting with people in their homes, at parties, or in restaurants?

(Circle One)

No difficulty at all	1
A little difficulty	2
Moderate difficulty	3
Extreme difficulty	4
Stopped doing this because of your eyesight	5
Stopped doing this for other reasons or not interested in doing this	6

A14: Because of your eyesight, how much difficulty do you have going out to see movies, plays, or sports events?

(Circle One)

No difficulty at all	1
A little difficulty	2
Moderate difficulty	3
Extreme difficulty	4
Stopped doing this because of your eyesight	5
Stopped doing this for other reasons or not interested in doing this	6

A15: Are you currently driving, at least once in a while?

	(Circle One)	
Yes	1	*Skip To Question A15c (page 7)*
No	2	*Go to Question A15a*

A15a: If NO: Have you never driven a car or have you given up driving?

	(Circle One)	
Never drove	1	*Skip To Section A, Part 3, Question A17 (page 8)*
Gave up	2	*Go to Question A15b*

A15b: IF YOU GAVE UP DRIVING: Was that mainly because of your eyesight, mainly for some other reason, or because of both your eyesight and other reasons?

	(Circle One)	
Mainly eyesight	1	*Skip To Section A, Part 3, Question A17 (page 8)*
Mainly other reasons	2	*Skip To Section A, Part 3, Question A17 (page 8)*
Both eyesight and other reasons	3	*Skip To Section A, Part 3, Question A17 (page 8)*

A15c: IF CURRENTLY DRIVING: How much difficulty do you have driving during the daytime in familiar places? Would you say you have:

(Circle One)

No difficulty at all	1
A little difficulty	2
Moderate difficulty	3
Extreme difficulty	4

A16: How much difficulty do you have driving at night? Would you say you have:

(Circle One)

No difficulty at all	1
A little difficulty	2
Moderate difficulty	3
Extreme difficulty	4
Stopped doing this because of your eyesight	5
Stopped doing this for other reasons or not interested in doing this	6

A16a: How much difficulty do you have driving in difficult conditions, such as in bad weather, during rush hour, on the freeway, or in city traffic? Would you say you have:

(Circle One)

No difficulty at all	1
A little difficulty	2
Moderate difficulty	3
Extreme difficulty	4
Stopped doing this because of your eyesight	5
Stopped doing this for other reasons or not interested in doing this	6

SECTION A PART 3 – RESPONSES TO VISION PROBLEMS

The next questions are about how things you do may be affected by your vision. For each one, please circle the number to indicate whether for you the statement is true for you all, most, some, a little, or none of the time.

(Circle One On Each Line)

	All of the time	Most of the time	Some of the time	A little of the time	None of the time
A17: **Do you accomplish less than you would like because of your vision?**	1	2	3	4	5
A18: **Are you limited in how long you can work or do other activities because of your vision?**	1	2	3	4	5
A19: **How much does pain or discomfort in or around your eyes, for example, burning, itching, or aching, keep you from doing what you'd like to be doing? Would you say:**	1	2	3	4	5

For each of the following statements, please circle the number to indicate whether for you the statement is definitely true, mostly true, mostly false, or definitely false for you or you are not sure.

(Circle One On Each Line)

	Definitely True	Mostly True	Not Sure	Mostly False	Definitely False
A20: **I stay home most of the time because of my eyesight.**	1	2	3	4	5
A21: **I feel frustrated a lot of the time because of my eyesight.**	1	2	3	4	5
A22: **I have much less control over what I do, because of my eyesight.**	1	2	3	4	5
A23: **Because of my eyesight, I have to rely too much on what other people tell me.**	1	2	3	4	5
A24: **I need a lot of help from others because of my eyesight.**	1	2	3	4	5
A25: **I worry about doing things that will embarrass myself or others, because of my eyesight.**	1	2	3	4	5

SECTION B – DESCRIBING YOUR OWN HEALTH TODAY (EQ-5D)

The first section of the questionnaire is about your general health **today.**

By placing a **tick (✓)** in one box in each group below, please indicate which statements best describe your own health state **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 ☐

The best health
you can imagine

- 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.

100
95
90
85
80
75
70
65
60
55
50
45
40
35
30
25
20
15
10
5
0

YOUR HEALTH TODAY =

The worst health
you can imagine

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SECTION C – HEALTH UTILITY INDEX QUESTIONNAIRE (HUI3)

This set of questions asks about various aspects of your health. When answering these questions please think about your health and your ability to do things on a day-to-day basis, during the past week. Please select one answer that best describes your level of ability or disability during the past week. Please indicate the selected answer by circling the number (e.g. 1, 2, 3, etc.) beside the answer.

Vision:

1 Able to see well enough to read ordinary newsprint and recognize a friend on the other side of the street, without glasses or contact lenses.

2 Able to see well enough to read ordinary newsprint and recognize a friend on the other side of the street, but with glasses.

3 Able to read ordinary newsprint with or without glasses but unable to recognize a friend on the other side of the street, even with glasses.

4 Able to recognize a friend on the other side of the street with or without glasses but unable to read ordinary newsprint, even with glasses.

5 Unable to read ordinary newsprint and unable to recognize a friend on the other side of the street, even with glasses.

6 Unable to see at all.

Hearing:

1 Able to hear what is said in a group conversation with at least three other people, without a hearing aid.

2 Able to hear what is said in a conversation with one other person in a quiet room without a hearing aid, but requires a hearing aid to hear what is said in a group conversation with at least three other people.

3 Able to hear what is said in a conversation with one other person in a quiet room with a hearing aid, and able to hear what is said in a group conversation with at least three other people, with a hearing aid.

4 Able to hear what is said in a conversation with one other person in a quiet room, without a hearing aid, but unable to hear what is said in a group conversation with at least three other people even with a hearing aid.

5 Able to hear what is said in a conversation with one other person in a quiet room, with a hearing aid, but unable to hear what is said in a group conversation with at least three other people even with a hearing aid.

6 Unable to hear at all.

Speech:

1. Able to be understood completely when speaking with strangers or friends.
2. Able to be understood partially when speaking with strangers but able to be understood completely when speaking with people who know me well.
3. Able to be understood partially when speaking with strangers or people who know me well.
4. Unable to be understood when speaking with strangers but able to be understood partially by people who know me well.
5. Unable to be understood when speaking to other people (or unable to speak at all).

Ambulation:

1. Able to walk around the neighbourhood without difficulty, and without walking equipment
2. Able to walk around the neighbourhood with difficulty; but does not require walking equipment or the help of another person.
3. Able to walk around the neighbourhood with walking equipment, but without the help of another person
4. Able to walk only short distances with walking equipment, and requires a wheelchair to get around the neighbourhood.
5. Unable to walk alone, even with walking equipment. Able to walk short distances with the help of another person, and requires a wheelchair to get around the neighbourhood.
6. Cannot walk at all.

Dexterity:

1. Full use of two hands and ten fingers.
2. Limitations in the use of hands or fingers, but does not require special tools or help of another person.
3. Limitations in the use of hands or fingers, is independent with use of special tools (does not require the help of another person).
4. Limitations in the use of hands or fingers, requires the help of another person for some tasks (not independent even with use of special tools).
5. Limitations in use of hands or fingers, requires the help of another person for most tasks (not independent even with use of special tools).
6. Limitations in use of hands or fingers, requires the help of another person for all tasks (not independent even with use of special tools).

Emotion:	1	Happy and interested in life.
	2	Somewhat happy.
	3	Somewhat unhappy.
	4	Very unhappy.
	5	So unhappy that life is not worthwhile.

Cognition:	1	Able to remember most things, think clearly and solve day to day problems.
	2	Able to remember most things, but have a little difficulty when trying to think and solve day to day problems.
	3	Somewhat forgetful, but able to think clearly and solve day to day problems.
	4	Somewhat forgetful, and have a little difficulty when trying to think or solve day to day problems.
	5	Very forgetful, and have great difficulty when trying to think or solve day to day problems.
	6	Unable to remember anything at all, and unable to think or solve day to day problems.

Pain:	1	Free of pain and discomfort.
	2	Mild to moderate pain that prevents no activities.
	3	Moderate pain that prevents a few activities.
	4	Moderate to severe pain that prevents some activities.
	5	Severe pain that prevents most activities.

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SECTION D – DESCRIBING YOUR EXPERIENCE OF GLAUCOMA^

In this section of the questionnaire we are interested in the importance you place on the different characteristics of glaucoma and its treatment effects.

Some of these statements may seem similar to earlier questions in the booklet. However, they are an important measurement tool for valuing how glaucoma and its treatment affect you.

Please tick one box **(✓)**, for each of the **categories D1-D6**, which best describes any difficulties you have had in the **last month** with yourself, or your eyes or vision. **Remember,** if you wear glasses or contact lenses please answer all of the following questions as though you were wearing them.

As a guide about what is meant by the questions please look at the booklet **'Guide to the Questionnaire Sections'**.

D1: Central and near vision

For example, do you have any difficulties with reading, writing, watching TV, sewing, card games, computer work, reading dials on cookers on clocks or any activities similar to these?

- No ☐
- Some difficulty ☐
- Quite a lot of difficulty ☐
- Severe difficulty ☐

D2: Lighting and glare

For example, do you have any difficulties adjusting from light to dark and vice-versa), dazzle from bright lights, or difficulties seeing in dim light?

- No ☐
- Some difficulty ☐
- Quite a lot of difficulty ☐
- Severe difficulty ☐

D3: Mobility

For example, **because of your eyesight,** do you have any difficulties crossing roads, walking along busy pavements, negotiating steps and kerbs, tripping over low objects (for example children in pushchairs or dogs) or difficulties driving (or stopping driving) because of your vision?

No	☐
Some difficulty	☐
Quite a lot of difficulty	☐
Severe difficulty	☐

D4: Activities of daily living

For example, **because of your eyesight**, do you have any difficulties with domestic, DIY or self-care tasks around the home? This category includes difficulties pouring liquid into containers (e.g. water into a glass), problems judging shelf height leading to difficulties putting objects into or retrieving them from cupboards, being unaware of open cupboard doors and similar problems.

No	☐
Some difficulty	☐
Quite a lot of difficulty	☐
Severe difficulty	☐

D5: Eye discomfort

For example, have any difficulties because of one or both eyes feeling gritty, sore, or tired?

No	☐
Some difficulty	☐
Quite a lot of difficulty	☐
Severe difficulty	☐

D6: Other possible effects of glaucoma or its treatment

For example, do you experience a dry mouth or a bitter after-taste, fatigue, shortness of breath or difficulties with sexual functioning?

No	☐
Some difficulty	☐
Quite a lot of difficulty	☐
Severe difficulty	☐

^ Glaucoma Profile Index, GPI Burr JM, Kilonzo M, Vale L, Ryan M. Developing a Preference based Glaucoma Utility Index using a Discrete Choice Experiment. *Optom Vis Sci. 2007 Aug; 84(8):797-808*

SECTION E - HEALTH CARE UTILISATION

Please print carefully within the boxes like this | 2 | 7 | or like this ✓

E1: Have you been to see a GP because of your eyes during the last 8 months?

Yes ☐

No ☐

If Yes, please give details:

E2: How many appointments did you attend with a GP? (at GP surgery)

E3: How many times did a GP visit you at home?

E4: How many times did you have a telephone conversation with a GP?

E5: Have you had any appointments with a community optician or optometrist in the last 8 months?

Yes (Go to E6) ☐

No (Skip to E7) ☐

E6: How many appointments with a community optician or optometrist did you attend?

E7: During the last 8 months have you had new spectacles or contact lenses?

Yes ☐

No ☐

E7a: If Yes (to E7 above), how much did you pay? £

This next question is about any appointments you may have had with <u>other health care workers</u> in the past 8 months

E8: During the last 8 months have you had an appointment with:

A District Nurse? Yes ☐ No ☐ If Yes, how many appointments did you have? ☐☐

A Practice Nurse? Yes ☐ No ☐ If Yes, how many appointments did you have? ☐☐

Other? Please specify Yes ☐ No ☐

________________________ How many appointments did you have? ☐☐

________________________ How many appointments did you have? ☐☐

This set of questions is about any <u>private</u> health care you may have had in the past 8 months

E9: During the last 8 months have you <u>paid for any private health care</u>? Yes ☐

If Yes please go to E9a, then E9b (below) if no please skip to E10 No ☐

E9a: If Yes, what sort of care did you pay for? ________________________

E9b: If Yes, how much did it cost? £

E10: During the last 8 months have you had any days off work or your usual activities because of your eyes? Yes ☐ No ☐ If Yes; how many days? ☐☐

E11: During the last 8 months, have you utilised any information or services related to your sensory impairment?

Yes ☐

No ☐

e.g. Low Vision Clinic, ☐

Services offered by the Royal National Institute of Blind People, etc. ☐

If another, could you please specify in the space provided:

E12: Are you currently in receipt of any form of travel allowance/concession as a result of your sensory impairment?

Yes ☐

No ☐

e.g. Disabled person's railcard ☐ **Dial-a-ride** ☐

Companion's permit ☐

If another, could you please specify in the space provided:

E13: Are you currently in receipt of any welfare benefits as a result of your sensory impairment?

Yes ☐

No ☐

e.g. Disability living allowance ☐ **Incapacity benefit** ☐

Carer's allowance ☐

If another, could you please specify in the space provided:

Do you think your glaucoma is getting worse?

(Somner, 2012- IOVS)

Yes ☐

No ☐

Date you filled in this questionnaire D D / M M / Y Y Y Y

Have you asked for any help to fill this questionnaire today?

Yes ☐

No ☐

THANK YOU

Thank you very much for your time and patience in filling in this questionnaire.

The information you have given us will be extremely useful in helping us carry out our research into treatments for Glaucoma.

It will be treated with the strictest confidence and kept securely.

Thank you again for your help.

If you would like any further information or have any queries about the study, please contact:

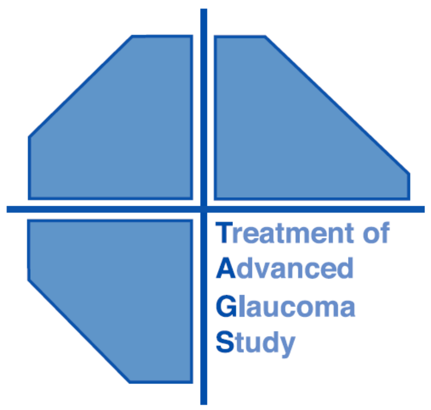
TAGS Study Office
Health Services Research Unit
University of Aberdeen
3rd Floor, Health Sciences Building
Foresterhill
Aberdeen
AB25 2ZD
UK

Telephone: 01224 438196
Email: tags@abdn.ac.uk
Website: www.tagsstudy.co.uk

The questionnaires are processed in Aberdeen at the
Centre for Health Care Randomised Trials (CHaRT), Health Services Research Unit,
Health Sciences Building, Foresterhill, Aberdeen, AB25 2ZD, UK.

Travel and time QUESTIONNAIRE

Study Number



TAGS

Treatment of Advanced Glaucoma Study

Travel and time Questionnaire

We would be very grateful if you could complete this questionnaire.
Thank you very much for helping us with our research.

CONFIDENTIAL

This questionnaire will help us to find out how much it costs you to use health services. We will ask about your most recent admission to hospital, your most recent outpatient appointment, your most recent appointment with a GP and finally, your most recent visit to specialist. We wish to know how much money and time were spent by you and any companion in attending these appointments and as a result of any hospital admission you may have had.

PART 1 - YOUR MOST RECENT ADMISSION TO HOSPITAL

If, in the last 12 months, you were not admitted to hospital, please tick box and go to **Part 2**. ☐

1. Please tick the box that best describes how you travelled. If you used more than one form of transport please indicate the way you travelled for the main (longest in terms of distance) part of your journey.

Bus	☐	Hospital car	☐
Train	☐	Ambulance	☐
Taxi	☐	Other (please specify)	______________
Private car	☐		

2. If you travelled by bus, train or taxi to hospital what was the total cost of the (one-way) journey? Please write the cost in the box below. Please put zero if you did not travel by bus, train or taxi at all or if you did not pay a fare.

Cost of (one-way) fare (£) ☐☐ - ☐☐ pence

3. If you travelled by private car about how many miles did you travel one-way? Please write the number of miles in the box below. Please put zero if you did not travel by private car at all.

Number of miles one-way ☐☐☐

4. If you travelled by private car and you or your companion had to pay a parking fee how much did this cost? Please write the cost in the box below. Please put zero if you did not pay a parking fee.

Expenditure on parking fee (£) ☐☐ - ☐☐ pence

5. When you went to hospital, how long did it take to travel there? Please write the number of hours and minutes in the box below.

Number of hours [ ][ ] - [ ][ ] minutes

6. When you were admitted to the hospital, how long did you spend there? Please write the number of days in the box below.

Number of days [ ][ ][ ]

7. What would you otherwise have been doing as your main activity if you had not had to be admitted to hospital? Please tick the box that best applies to you.

Housework	[ ]	Paid work	[ ]
Childcare	[ ]	Voluntary work	[ ]
Caring for a relative or friend	[ ]	Leisure activities	[ ]
Unemployed	[ ]	Other (please specify)	______________

8. When you were admitted to hospital, did anyone come with you? Please tick the appropriate response.

Yes [ ] Go to **Question 9**

No [ ] Go to **Part 2**

9. Please tick the box(es) that best describe the person(s) who accompanied you to the hospital. You may tick more than one response if appropriate.

Partner/spouse	[ ]	Paid caregiver	[ ]
Other relative	[ ]	Other (please specify)	______________
Friend	[ ]		

10. If your main companion travelled with you by bus or train approximately how much did they pay (one-way) in fares? Please write the approximate cost in the box below. Please put zero if your main companion did not travel by bus or train at all.

Cost of (one-way) fare (£) ☐☐ - ☐☐ pence

11. Please tick the box that best describes what your main companion would otherwise have been doing as their main activity if they had not gone with you to the hospital.

Housework	☐	Paid work	☐
Childcare	☐	Voluntary work	☐
Caring for a relative or friend	☐	Leisure activities	☐
Unemployed	☐	Other (please specify)	____________

12. Did your main companion take time off from paid work (or business activity if self-employed). Please tick the appropriate response.

Yes ☐ Go to **Question 13**

No ☐ Go to **Part 2**

13. Please write the number of hours your companion took off from paid work (or business activity if self-employed) in the box below. Please put zero if your main companion did not take time off from paid work (or business activity if self-employed) to accompany you to the hospital.

Number of hours ☐☐

14. Whilst you were in hospital, approximately how many times did your main companion come to visit you?

Number of times ☐☐

PART 2 - YOUR MOST RECENT OUTPATIENT VISIT

If, in the last 12 months, you did not have an outpatient appointment, please tick box and go to **Part 3** ☐

1. Please tick the box that best describes how you travelled. If you used more than one form of transport please indicate the way you travelled for the main (longest in terms of distance) part of your journey.

Bus	☐	Hospital car	☐
Train	☐	Ambulance	☐
Taxi	☐	Other (please specify)	____________________
Private car	☐		

2. If you travelled by bus, taxi or train to your outpatient appointment what was the total cost of the (one-way) journey? Please write the cost in the box below. Please put zero if you did not travel by bus, train or taxi at all or if you did not pay a fare.

Cost of (one-way) fare (£) ☐☐ - ☐☐ pence

3. If you travelled by private car about how many miles did you travel one-way? Please write the number of miles in the box below. Please put zero if you did not travel by private car at all.

Number of miles one-way ☐☐☐

4. If you travelled by private car and you or your companion had to pay a parking fee how much did this cost? Please write the cost in the box below. Please put zero if you did not pay a parking fee.

Expenditure on parking fee (£) ☐☐ - ☐☐ pence

5. When you went to your outpatient appointment, how long did it take to travel there? Please write the number of hours and minutes in the box below.

Number of hours ☐☐ - ☐☐ minutes

6. When you had your outpatient appointment, how long did you spend there? Please write the number hours and minutes in the box below.

Number of hours ☐☐ - ☐☐ minutes

7. Please tick the box that best describes what you otherwise would have been doing as your main activity if you had not been visiting outpatients?

Housework	☐	Paid work	☐
Childcare	☐	Voluntary work	☐
Caring for a relative or friend	☐	Leisure activities	☐
Unemployed	☐	Other (please specify)	________________

8. When you visited outpatients did anyone come with you? Please tick the appropriate box.

Yes ☐ Go to **Question 9**

No ☐ Go to **Part 3**

9. Please tick the box(es) that best describe the person(s) who accompanied you to outpatients. You may tick more than one response if appropriate.

Partner/spouse	☐	Paid caregiver	☐
Other relative	☐	Other (please specify)	________________
Friend	☐		

10. If your main companion travelled with you by bus or train approximately how much did

they pay (one-way) in fares? Please write the approximate cost in the box below. Please put zero if your main companion did not travel by bus or train at all.

Cost of (one-way) fare (£) ☐☐ - ☐☐ pence

11. Please tick the box that best describes what your main companion would otherwise have been doing as their main activity if they had not gone with you to outpatients.

Housework	☐	Paid work	☐
Childcare	☐	Voluntary work	☐
Caring for a relative or friend	☐	Leisure activities	☐
Unemployed	☐	Other (please specify)	________

PART 3 - YOUR MOST RECENT GP APPOINTMENT

If, in the last 12 months, you did not have a GP appointment, please tick box and go to **Part 4** ☐

1. Please tick the box that best describes how you travelled to your most recent GP appointment. If you used more than one form of transport please indicate the way you travelled for the main (longest in terms of distance) part of your journey.

Walked	☐	Bus	☐
Cycled	☐	Taxi	☐
Private car	☐	Other (please specify)	________

2. If you travelled by bus or taxi, what was the cost of the (one-way) fare? Please write the cost in the box below. Please put zero if you did not travel by bus or taxi or if you did not pay the fare.

Cost of (one-way) fare (£) ☐☐ - ☐☐ pence

3. If you travelled by private car about how many miles did you travel one-way? Please write the number of miles in the box below. Please put zero if you did not travel by private car at all.

Number of miles one-way ☐☐☐

4. If you travelled by private car and you or a companion had to pay a parking fee how much did this cost? Please write the cost in the box below. Please put zero if you did not pay for parking.

Expenditure on parking fee (£) ☐☐ - ☐☐ Pence

5. When you visited the GP, how long did it take to travel there? Please write the number of minutes in the box below.

Number of minutes ☐☐☐

6. When you visited the GP, how long did you spend there? Please write the number minutes in the box below. Please include in your answer the time spent waiting and also the time spent with the doctors and nurses.

Number of minutes ☐☐☐

7. Please tick the box that best describes what you otherwise would have been doing as your main activity if you had not visited the GP.

Housework	☐	Paid work	☐
Childcare	☐	Voluntary work	☐
Caring for a relative or friend	☐	Leisure activities	☐
Unemployed	☐	Other (please specify)	______________

8. When you visited the GP did anyone come with you? Please tick the appropriate response.

Yes ☐ Go to **Question 9**

No ☐ Go to **Part 4**

9. Please tick the box(es) that best describe the person(s) who accompanied you to the GP's surgery. You may tick more than one response if appropriate.

Partner/spouse	☐	Paid caregiver	☐
Other relative	☐	Other (please specify)	________________
Friend	☐		

10. If your main companion travelled with you by bus how much approximately did they pay (one-way) in fares (if anything)? Please write the cost in the box below. Please put zero if your main companion did not travel by bus at all.

Cost of (one-way) fare (£) ☐☐ - ☐☐ Pence

11. Please tick the box that best describes what your main companion would otherwise have been doing as their main activity if they had not gone with you to the GP's surgery.

Housework	☐	Paid work	☐
Childcare	☐	Voluntary work	☐
Caring for a relative or friend	☐	Leisure activities	☐
Unemployed	☐	Other (please specify)	________________

PART 4 - YOUR MOST RECENT VISIT TO A COMMUNITY OPTICIAN OR OPTOMETRIST

1. Please tick the box that best describes how you travelled. If you used more than one form of transport please indicate the way you travelled for the main (longest in terms of distance) part of your journey.

Bus	☐	Hospital car	☐
Train	☐	Ambulance	☐
Taxi	☐	Other (please specify)	______________________
Private car	☐		

2. If you travelled by bus, train or taxi to an optician or optometrist what was the total cost of the (one-way) journey? Please write the cost in the box below. Please put zero if you did not travel by bus, train or taxi at all or if you did not pay a fare.

Cost of (one-way) fare (£) ☐☐ - ☐☐ pence

3. If you travelled by private car about how many miles did you travel one-way? Please write the number of miles in the box below. Please put zero if you did not travel by private car at all.

Number of miles one-way ☐☐☐

4. If you travelled by private car and you or your companion had to pay a parking fee how much did this cost? Please write the cost in the box below. Please put zero if you did not pay a parking fee.

Expenditure on parking fee (£) ☐☐ - ☐☐ pence

5. When you visited the optician or optometrist, how long did it take to travel there? Please write the number of minutes in the box below.

Number of minutes ☐☐☐

6. When you visited the optician or optometrist how long did you spend there? Please write the number hours and minutes in the box below.

Number of hours ☐☐ - ☐☐ minutes

7. What would you otherwise have been doing as your main activity if you had not had visit the Specialist? Please tick the box that best applies to you.

Housework	☐	Paid work	☐
Childcare	☐	Voluntary work	☐
Caring for a relative or friend	☐	Leisure activities	☐
Unemployed	☐	Other (please specify)	______________

8. When you went to the optician or optometrist, did anyone come with you? Please tick the appropriate response.

Yes ☐ Go to **Question 9**

No ☐ Thank-you for completing this questionnaire

9. Please tick the box(es) that best describe the person(s) who accompanied you to the optician or optometrist. You may tick more than one response if appropriate.

Partner/spouse	☐	Paid caregiver	☐
Other relative	☐	Other (please specify)	______________
Friend	☐		

10. If your main companion travelled with you by bus how much approximately did they pay (one-way) in fares (if anything)? Please write the cost in the box below. Please put zero if your main companion did not travel by bus at all.

Cost of (one-way) fare (£) ☐☐ - ☐☐ pence

11. Please tick the box that best describes what your main companion would otherwise have been doing as their main activity if they had not gone with you to the Specialist.

Housework	☐	Paid work	☐
Childcare	☐	Voluntary work	☐
Caring for a relative or friend	☐	Leisure activities	☐
Unemployed	☐	Other (please specify)	________________

THANK YOU

Thank you very much for your time and patience in filling in this questionnaire. Please hand the questionnaire back to the research nurse or return it in the enclosed reply-paid envelope to the Trial Office in Aberdeen.

The information you have given us will be extremely useful in helping us carry out research. It will be treated with the strictest confidence and kept securely.

If you would like any further information or have any queries about the study, please contact:

TAGS Office
Centre for Healthcare Randomised Trials
Health Services Research Unit
University of Aberdeen
3rd Floor, Health Sciences Building
Foresterhill
Aberdeen
AB25 2ZD

Telephone: 01224 438196

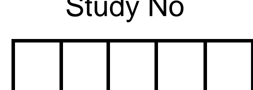
Email: tags@abdn.ac.uk

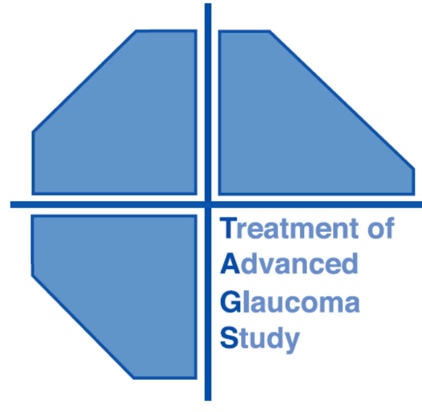
Website: www.tagsstudy.co.uk

The questionnaires are processed in Aberdeen at the Centre for Healthcare Randomised Trials (CHaRT), Health Services Research Unit, Health Sciences Building, Foresterhill, ABERDEEN, AB25 2ZD.

24 MONTH QUESTIONNAIRE

Study No





TAGS

Treatment of Advanced Glaucoma Study

A multicentre randomised controlled trial comparing primary medical treatment with primary trabeculectomy for people with newly diagnosed advanced glaucoma.

PARTICIPANT QUESTIONNAIRE

Thank you for helping us with our research.
We would be very grateful if you could complete this questionnaire.

CONFIDENTIAL

24 MONTH

The following questionnaire is broken down into five sections (Section A - Section E as detailed below). Please work through all the sections as best you can from start to finish.

Some of the sections ask you to indicate your answers to the questions by placing a tick **(✓)** in the appropriate box, and other sections ask you to circle your answer out of a list that is provided. Please read the questions carefully and answer each one as accurately as you can.

If you have any difficulties reading the text or understanding the meaning of any questions, then please ask a TAGS member of staff or contact the central office in Aberdeen.

The sections covered in this questionnaire are as follows:

Section A: Visual Functioning Questionnaire (split into 3 parts)

Part 1 - General Health and Vision

Part 2 - Difficulty with activities

Part 3 - Response to vision problems

Section B: Describing your own health today

Section C: Health Utility Index

Section D: Describing your experience of Glaucoma

Section E: Health Care Utilisation

Please try to complete all the questions. Some of the sections ask you to indicate your answers to the questions by placing a tick **(✓)** in the appropriate box, and other sections ask you to circle your answer out of a list that is provided. Please read the questions carefully and answer each one as accurately as you can.

SECTION A - Visual Functioning Questionnaire (NEI-VFQ-25)

The following section is a survey with statements about problems, which involve your vision, or feelings that you have about your eye condition. After each question please choose the response that best describes your situation. Please take as much time as you need to answer each question. All your answers are confidential. In order for this survey to improve our knowledge about eye problems and how they affect your quality of life, your answers must be as accurate as possible. Remember, if you wear glasses or contact lenses, please answer all of the following questions as though you were wearing them.

INSTRUCTIONS:

1. In general we would like to have people try to complete these forms on their own. If you find that you need assistance, please feel free to ask the project staff and they will assist you.
2. Please answer every question (unless you are asked to skip questions because they don't apply to you).
3. Answer the questions by circling the appropriate number.
4. If you are unsure of how to answer a question, please give the best answer you can and make a comment in the left margin.
5. If you have any questions, please feel free to ask a member of the project staff, and they will be glad to help you.

STATEMENT OF CONFIDENTIALITY:

All information that would permit identification of any person who completed this questionnaire will be regarded as strictly confidential. Such information will be used only for the purposes of this study and will not be disclosed or released for any other purposes without prior consent, except as required by law.

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SECTION A – PART 1 GENERAL HEALTH AND VISION (NEI-VFQ-25)

A1: In general, would you say your overall health is:

(Circle One)

Excellent	1
Very Good	2
Good	3
Fair	4
Poor	5

A2: At the present time, would you say your eyesight using both eyes (with glasses or contact lenses, if you wear them) is excellent, good, fair, poor, or very poor or are you completely blind?

(Circle One)

Excellent	1
Good	2
Fair	3
Poor	4
Very Poor	5
Completely Blind	6

A3: How much of the time do you worry about your eyesight?

(Circle One)

None of the time	1
A little of the time	2
Some of the time	3
Most of the time	4
All of the time	5

A4: How much pain or discomfort have you had in and around your eyes (for example, burning, itching, or aching)? Would you say it is:

(Circle One)

None	1
Mild	2
Moderate	3
Severe, or	4
Very severe	5

SECTION A - PART 2 DIFFICULTY WITH ACTIVITIES

The next questions are about how much difficulty, if any, you have doing certain activities wearing your glasses or contact lenses if you use them for that activity.

A5: How much difficulty do you have reading ordinary print in newspapers? Would you say you have:

(Circle One)

No difficulty at all	1
A little difficulty	2
Moderate difficulty	3
Extreme difficulty	4
Stopped doing this because of your eyesight	5
Stopped doing this for other reasons or not interested in doing this	6

A6: How much difficulty do you have doing work or hobbies that require you to see well up close, such as cooking, sewing, fixing things around the house, or using hand tools? Would you say:

(Circle One)

No difficulty at all	1
A little difficulty	2
Moderate difficulty	3
Extreme difficulty	4
Stopped doing this because of your eyesight	5
Stopped doing this for other reasons or not interested in doing this	6

A7: Because of your eyesight, how much difficulty do you have finding something on a crowded shelf?

(Circle One)

No difficulty at all	1
A little difficulty	2
Moderate difficulty	3
Extreme difficulty	4
Stopped doing this because of your eyesight	5
Stopped doing this for other reasons or not interested in doing this	6

A8: How much difficulty do you have reading street signs or the names of stores?

(Circle One)

No difficulty at all	1
A little difficulty	2
Moderate difficulty	3
Extreme difficulty	4
Stopped doing this because of your eyesight	5
Stopped doing this for other reasons or not interested in doing this	6

A9: Because of your eyesight, how much difficulty do you have going down steps, stairs, or curbs in dim light or at night?

(Circle One)

No difficulty at all	1
A little difficulty	2
Moderate difficulty	3
Extreme difficulty	4
Stopped doing this because of your eyesight	5
Stopped doing this for other reasons or not interested in doing this	6

A10: Because of your eyesight, how much difficulty do you have noticing objects off to the side while you are walking along?

(Circle One)

No difficulty at all	1
A little difficulty	2
Moderate difficulty	3
Extreme difficulty	4
Stopped doing this because of your eyesight	5
Stopped doing this for other reasons or not interested in doing this	6

A11: Because of your eyesight, how much difficulty do you have seeing how people react to things you say?

(Circle One)

No difficulty at all	1
A little difficulty	2
Moderate difficulty	3
Extreme difficulty	4
Stopped doing this because of your eyesight	5
Stopped doing this for other reasons or not interested in doing this	6

A12: Because of your eyesight, how much difficulty do you have picking out and matching your own clothes?

(Circle One)

No difficulty at all	1
A little difficulty	2
Moderate difficulty	3
Extreme difficulty	4
Stopped doing this because of your eyesight	5
Stopped doing this for other reasons or not interested in doing this	6

A13: Because of your eyesight, how much difficulty do you have visiting with people in their homes, at parties, or in restaurants?

(Circle One)

No difficulty at all	1
A little difficulty	2
Moderate difficulty	3
Extreme difficulty	4
Stopped doing this because of your eyesight	5
Stopped doing this for other reasons or not interested in doing this	6

A14: Because of your eyesight, how much difficulty do you have going out to see movies, plays, or sports events?

(Circle One)

No difficulty at all	1
A little difficulty	2
Moderate difficulty	3
Extreme difficulty	4
Stopped doing this because of your eyesight	5
Stopped doing this for other reasons or not interested in doing this	6

A15: Are you currently driving, at least once in a while?

	(Circle One)	
Yes	1	*Skip To Question A15c (page 7)*
No	2	*Go to Question A15a*

A15a: If NO: Have you never driven a car or have you given up driving?

	(Circle One)	
Never drove	1	*Skip To Section A, Part 3, Question A17 (page 8)*
Gave up	2	*Go to Question A15b*

A15b: IF YOU GAVE UP DRIVING: Was that mainly because of your eyesight, mainly for some other reason, or because of both your eyesight and other reasons?

	(Circle One)	
Mainly eyesight	1	*Skip To Section A, Part 3, Question A17 (page 8)*
Mainly other reasons	2	*Skip To Section A, Part 3, Question A17 (page 8)*
Both eyesight and other reasons	3	*Skip To Section A, Part 3, Question A17 (page 8)*

A15c: IF CURRENTLY DRIVING: How much difficulty do you have driving during the daytime in familiar places? Would you say you have:

(Circle One)

No difficulty at all	1
A little difficulty	2
Moderate difficulty	3
Extreme difficulty	4

A16: How much difficulty do you have driving at night? Would you say you have:

(Circle One)

No difficulty at all	1
A little difficulty	2
Moderate difficulty	3
Extreme difficulty	4
Stopped doing this because of your eyesight	5
Stopped doing this for other reasons or not interested in doing this	6

A16a: How much difficulty do you have driving in difficult conditions, such as in bad weather, during rush hour, on the freeway, or in city traffic? Would you say you have:

(Circle One)

No difficulty at all	1
A little difficulty	2
Moderate difficulty	3
Extreme difficulty	4
Stopped doing this because of your eyesight	5
Stopped doing this for other reasons or not interested in doing this	6

SECTION A PART 3 – RESPONSES TO VISION PROBLEMS

The next questions are about how things you do may be affected by your vision. For each one, please circle the number to indicate whether for you the statement is true for you all, most, some, a little, or none of the time.

(Circle One On Each Line)

	All of the time	Most of the time	Some of the time	A little of the time	None of the time
A17: **Do you accomplish less than you would like because of your vision?**	*1*	*2*	*3*	*4*	*5*
A18: **Are you limited in how long you can work or do other activities because of your vision?**	*1*	*2*	*3*	*4*	*5*
A19: **How much does pain or discomfort in or around your eyes, for example, burning, itching, or aching, keep you from doing what you'd like to be doing? Would you say:**	*1*	*2*	*3*	*4*	*5*

For each of the following statements, please circle the number to indicate whether for you the statement is definitely true, mostly true, mostly false, or definitely false for you or you are not sure.

(Circle One On Each Line)

	Definitely True	Mostly True	Not Sure	Mostly False	Definitely False
A20: **I stay home most of the time because of my eyesight.**	*1*	*2*	*3*	*4*	*5*
A21: **I feel frustrated a lot of the time because of my eyesight.**	*1*	*2*	*3*	*4*	*5*
A22: **I have much less control over what I do, because of my eyesight.**	*1*	*2*	*3*	*4*	*5*
A23: **Because of my eyesight, I have to rely too much on what other people tell me.**	*1*	*2*	*3*	*4*	*5*
A24: **I need a lot of help from others because of my eyesight.**	*1*	*2*	*3*	*4*	*5*
A25: **I worry about doing things that will embarrass myself or others, because of my eyesight.**	*1*	*2*	*3*	*4*	*5*

SECTION B – DESCRIBING YOUR OWN HEALTH TODAY (EQ-5D)

The first section of the questionnaire is about your general health **today.**

By placing a **tick (✓)** in one box in each group below, please indicate which statements best describe your own health state **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 =

The best health you can imagine

100
95
90
85
80
75
70
65
60
55
50
45
40
35
30
25
20
15
10
5
0

The worst health you can imagine

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SECTION C – HEALTH UTILITY INDEX QUESTIONNAIRE (HUI3)

This set of questions asks about various aspects of your health. When answering these questions please think about your health and your ability to do things on a day-to-day basis, during the past week. Please select one answer that best describes your level of ability or disability during the past week. Please indicate the selected answer by circling the number (e.g. 1, 2, 3, etc.) beside the answer.

Vision:

1 Able to see well enough to read ordinary newsprint and recognize a friend on the other side of the street, without glasses or contact lenses.

2 Able to see well enough to read ordinary newsprint and recognize a friend on the other side of the street, but with glasses.

3 Able to read ordinary newsprint with or without glasses but unable to recognize a friend on the other side of the street, even with glasses.

4 Able to recognize a friend on the other side of the street with or without glasses but unable to read ordinary newsprint, even with glasses.

5 Unable to read ordinary newsprint and unable to recognize a friend on the other side of the street, even with glasses.

6 Unable to see at all.

Hearing:

1 Able to hear what is said in a group conversation with at least three other people, without a hearing aid.

2 Able to hear what is said in a conversation with one other person in a quiet room without a hearing aid, but requires a hearing aid to hear what is said in a group conversation with at least three other people.

3 Able to hear what is said in a conversation with one other person in a quiet room with a hearing aid, and able to hear what is said in a group conversation with at least three other people, with a hearing aid.

4 Able to hear what is said in a conversation with one other person in a quiet room, without a hearing aid, but unable to hear what is said in a group conversation with at least three other people even with a hearing aid.

5 Able to hear what is said in a conversation with one other person in a quiet room, with a hearing aid, but unable to hear what is said in a group conversation with at least three other people even with a hearing aid.

6 Unable to hear at all.

Speech:

1	Able to be understood completely when speaking with strangers or friends.
2	Able to be understood partially when speaking with strangers but able to be understood completely when speaking with people who know me well.
3	Able to be understood partially when speaking with strangers or people who know me well.
4	Unable to be understood when speaking with strangers but able to be understood partially by people who know me well.
5	Unable to be understood when speaking to other people (or unable to speak at all).

Ambulation:

1	Able to walk around the neighbourhood without difficulty, and without walking equipment
2	Able to walk around the neighbourhood with difficulty; but does not require walking equipment or the help of another person.
3	Able to walk around the neighbourhood with walking equipment, but without the help of another person
4	Able to walk only short distances with walking equipment, and requires a wheelchair to get around the neighbourhood.
5	Unable to walk alone, even with walking equipment. Able to walk short distances with the help of another person, and requires a wheelchair to get around the neighbourhood.
6	Cannot walk at all.

Dexterity:

1	Full use of two hands and ten fingers.
2	Limitations in the use of hands or fingers, but does not require special tools or help of another person.
3	Limitations in the use of hands or fingers, is independent with use of special tools (does not require the help of another person).
4	Limitations in the use of hands or fingers, requires the help of another person for some tasks (not independent even with use of special tools).
5	Limitations in use of hands or fingers, requires the help of another person for most tasks (not independent even with use of special tools).
6	Limitations in use of hands or fingers, requires the help of another person for all tasks (not independent even with use of special tools).

Emotion:

1 Happy and interested in life.

2 Somewhat happy.

3 Somewhat unhappy.

4 Very unhappy.

5 So unhappy that life is not worthwhile.

Cognition:

1 Able to remember most things, think clearly and solve day to day problems.

2 Able to remember most things, but have a little difficulty when trying to think and solve day to day problems.

3 Somewhat forgetful, but able to think clearly and solve day to day problems.

4 Somewhat forgetful, and have a little difficulty when trying to think or solve day to day problems.

5 Very forgetful, and have great difficulty when trying to think or solve day to day problems.

6 Unable to remember anything at all, and unable to think or solve day to day problems.

Pain:

1 Free of pain and discomfort.

2 Mild to moderate pain that prevents no activities.

3 Moderate pain that prevents a few activities.

4 Moderate to severe pain that prevents some activities.

5 Severe pain that prevents most activities.

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SECTION D – DESCRIBING YOUR EXPERIENCE OF GLAUCOMA^

In this section of the questionnaire we are interested in the importance you place on the different characteristics of glaucoma and its treatment effects.

Some of these statements may seem similar to earlier questions in the booklet. However, they are an important measurement tool for valuing how glaucoma and its treatment affect you.

Please tick one box **(✓)**, for each of the **categories D1-D6**, which best describes any difficulties you have had in the **last month** with yourself, or your eyes or vision. **Remember,** if you wear glasses or contact lenses please answer all of the following questions as though you were wearing them.

As a guide about what is meant by the questions please look at the booklet **'Guide to the Questionnaire Sections'**.

D1: Central and near vision

For example, do you have any difficulties with reading, writing, watching TV, sewing, card games, computer work, reading dials on cookers on clocks or any activities similar to these?

No ☐
Some difficulty ☐
Quite a lot of difficulty ☐
Severe difficulty ☐

D2: Lighting and glare

For example, do you have any difficulties adjusting from light to dark and vice-versa), dazzle from bright lights, or difficulties seeing in dim light?

No ☐
Some difficulty ☐
Quite a lot of difficulty ☐
Severe difficulty ☐

D3: Mobility

For example, **because of your eyesight,** do you have any difficulties crossing roads, walking along busy pavements, negotiating steps and kerbs, tripping over low objects (for example children in pushchairs or dogs) or difficulties driving (or stopping driving) because of your vision?

No ☐
Some difficulty ☐
Quite a lot of difficulty ☐
Severe difficulty ☐

D4: Activities of daily living

For example, **because of your eyesight**, do you have any difficulties with domestic, DIY or self-care tasks around the home? This category includes difficulties pouring liquid into containers (e.g. water into a glass), problems judging shelf height leading to difficulties putting objects into or retrieving them from cupboards, being unaware of open cupboard doors and similar problems.

No ☐
Some difficulty ☐
Quite a lot of difficulty ☐
Severe difficulty ☐

D5: Eye discomfort

For example, have any difficulties because of one or both eyes feeling gritty, sore, or tired?

No ☐
Some difficulty ☐
Quite a lot of difficulty ☐
Severe difficulty ☐

D6: Other possible effects of glaucoma or its treatment

For example, do you experience a dry mouth or a bitter after taste, fatigue, shortness of breath or difficulties with sexual functioning?

No ☐
Some difficulty ☐
Quite a lot of difficulty ☐
Severe difficulty ☐

^ Glaucoma Profile Index, GPI Burr JM, Kilonzo M, Vale L, Ryan M. Developing a Preference based Glaucoma Utility Index using a Discrete Choice Experiment. *Optom Vis Sci. 2007 Aug; 84(8):797-808.*

SECTION E - HEALTH CARE UTILISATION

Please print carefully within the boxes like this | 2 | 7 | **or like this** ✓

E1: Have you been to see a GP because of your eyes during the last 12 months?

Yes ☐

No ☐

If Yes, please give details:

☐

E2: How many appointments did you attend with a GP? (at GP surgery) ☐☐

E3: How many times did a GP visit you at home? ☐☐

E4: How many times did you have a telephone conversation with a GP? ☐☐

E5: Have you had any appointments with a community optician or optometrist in the last 12 months?

Yes (Go to E6) ☐

No (Skip to E7) ☐

E6: How many appointments with a community optician or optometrist did you attend? ☐☐

E7: During the last 12 months have you had new spectacles or contact lenses?

Yes ☐

No ☐

E7a: If Yes (to E7 above), how much did you pay? £

This next question is about any appointments you may have had with <u>other health care workers</u> in the past 12 months.

E8: During the last 12 months have you had an appointment with:

A District Nurse? Yes ☐ No ☐ If Yes, how many appointments did you have? ☐☐

A Practice Nurse? Yes ☐ No ☐ If Yes, how many appointments did you have? ☐☐

Other? Please specify Yes ☐ No ☐

________________ How many appointments did you have? ☐☐

________________ How many appointments did you have? ☐☐

This set of questions is about any <u>private</u> health care you may have had in the past 12 months.

E9: During the last 12 months have you <u>paid for any private health care</u>? Yes ☐ No ☐

If Yes please go to E9a, then E9b (below) if no please skip to E10

E9a: If Yes, what sort of care did you pay for? ________________

E9b: If Yes, how much did it cost? £

E10: During the last 12 months have you had any days off work or your usual activities because of your eyes? Yes ☐ No ☐ If Yes; how many days? ☐☐

E11: During the last 12 months, have you utilised any information or services related to your sensory impairment?

Yes ☐

No ☐

e.g. Low Vision Clinic, ☐

Services offered by the Royal National Institute of Blind People, etc. ☐

If another, could you please specify in the space provided:

E12: Are you currently in receipt of any form of travel allowance/concession as a result of your sensory impairment?

Yes ☐

No ☐

e.g. Disabled person's railcard ☐ **Dial-a-ride** ☐

Companion's permit ☐

If another, could you please specify in the space provided:

E13: Are you currently in receipt of any welfare benefits as a result of your sensory impairment?

Yes ☐

No ☐

e.g. Disability living allowance ☐ **Incapacity benefit** ☐

Carer's allowance ☐

If another, could you please specify in the space provided:

Do you think your glaucoma is getting worse? **Yes** ☐ **No** ☐

(Somner, 2012- IOVS)

Date you filled in this questionnaire D D / M M / Y Y Y Y

Have you asked for any help to fill this questionnaire today? **Yes** ☐ **No** ☐

THANK YOU

Thank you very much for your time and patience in filling in this questionnaire.

The information you have given us will be extremely useful in helping us carry out our research into treatments for Glaucoma.

It will be treated with the strictest confidence and kept securely.

Thank you again for your help.

If you would like any further information or have any queries about the study, please contact:

TAGS Study Office
Health Services Research Unit
University of Aberdeen
3rd Floor, Health Sciences Building
Foresterhill
Aberdeen
AB25 2ZD
UK

Telephone: 01224 438196
Email: tags@abdn.ac.uk
Website: www.tagsstudy.co.uk

The questionnaires are processed in Aberdeen at the
Centre for Health Care Randomised Trials (CHaRT), Health Services Research Unit,
Health Sciences Building, Foresterhill, Aberdeen, AB25 2ZD, UK.

DISCRETE CHOICE EXPERIMENT

Study No

TAGS

Treatment of Advanced Glaucoma Study

A multicentre randomised controlled trial comparing primary medical treatment with primary trabeculectomy for people with newly diagnosed advanced glaucoma

PARTICIPANT QUESTIONNAIRE

Discrete Choice Experiment

Thank you for helping us with our research.
We would be very grateful if you could complete this questionnaire.

CONFIDENTIAL

Discrete Choice Experiment

QUESTIONNAIRE

Before answering the questions please read the **'Guide to the Discrete Choice Experiment '**.

Please complete all of the questions. If you make a mistake when answering a question, please draw a line through the undesired response and then record your desired response.

After answering all of the questions, please return it in the Freepost envelope supplied.

Section 1 - Making choices

In this section you are presented with choices, each describing two health state situations: Situation A and B. We would like you to imagine that you have these difficulties and ask you to pick the scenario you think is worse. You may not like either situation but please choose the one that is less preferable to you by putting a tick in the appropriate box. Please tick just ONE box for every question. Again, **please choose one situation only.**

To help you make your choices please refer to the Guide about aspects of quality of life that may be affected in glaucoma and associated levels of difficulty (Guide to the Discrete Choice Experiment).

Please see the following EXAMPLE QUESTION to help you fill out the following questions.

Example Question: Which situation is worse for you?	
SITUATION A	SITUATION B
No difficulty with: • Central and near vision • Lighting and glare • Mobility **Some difficulty** with: • Activities of daily living • Local eye discomfort • The effects of glaucoma and its treatment	**No difficulty** with: • Central and near vision **Some difficulty** with: • Lighting and glare **Quite a lot of difficulty** with: • Activities of daily living • The effects of glaucoma and its treatment **Severe difficulty** with: • Mobility • Local eye discomfort
(Tick one box only)	
Situation A ☐	**Situation B** ✓

In this case the person answering this question thought that the worse option was Situation B:

- Having no difficulty with central and near vision.
- Some difficulty with lighting and glare.
- Quite a lot of difficulty with activities of daily living and the effects of glaucoma and its treatment.
- Severe difficulty with mobility and local eye discomfort.

This is compared with **Situation A**:

- Having no difficulty with central and near vision, lighting and glare and mobility.
- Some difficulty with activities of daily living, local eye discomfort and the effects of glaucoma and its treatment.

Start making your choices

<table>
<tr><th colspan="2">Question 1 Which situation is worse for you?</th></tr>
<tr><td>SITUATION A</td><td>SITUATION B</td></tr>
<tr><td>No difficulty with:
• Central and near vision
• Local eye discomfort
Some difficulty with:
• Activities of daily living
• The effects glaucoma and its treatment
Severe difficulty with:
• Mobility
• Lighting and glare</td><td>Some difficulty with:
• Lighting and glare
• Mobility
Quite a lot of difficulty with:
• Activities of daily living
• Local eye discomfort
Severe difficulty with:
• Central and near vision
• The effects glaucoma and its treatment</td></tr>
<tr><td colspan="2">(Tick one box only)
Situation A ☐ Situation B ☐</td></tr>
</table>

<table>
<tr><th colspan="2">Question 2 Which situation is worse for you?</th></tr>
<tr><td>SITUATION A</td><td>SITUATION B</td></tr>
<tr><td>No difficulty with:
• Activities of daily living
Some difficulty with:
• Central and near vision
• Local eye discomfort
• The effects of glaucoma and its treatments
Quite a lot of difficulty with:
• Lighting and glare
Severe difficulty with:
• Mobility</td><td>No difficulty with:
• Lighting and glare
• Mobility
• Local eye discomfort
Quite a lot of difficulty with:
• Central and near vision
Severe difficulty with:
• Activities of daily living
• The effects of glaucoma and its treatments</td></tr>
<tr><td colspan="2">(Tick one box only)
Situation A ☐ Situation B ☐</td></tr>
</table>

<table>
<tr><th colspan="2">Question 3 Which situation is worse for you?</th></tr>
<tr><td>SITUATION A</td><td>SITUATION B</td></tr>
<tr><td>No difficulty with:
• Central and near vision
Some difficulty with:
• The effects of glaucoma and its treatments
Quite a lot of difficulty with:
• Lighting and glare
• Mobility
• Activities of daily living
Severe difficulty with:
• Local eye discomfort</td><td>No difficulty with:
• Lighting and glare
• Activities of daily living
• The effects of glaucoma and its treatments
Some difficulty with:
• Central and near vision
Quite a lot of difficulty with:
• Local eye discomfort
Severe difficulty with:
• Mobility</td></tr>
<tr><td colspan="2">(Tick one box only)
Situation A ☐ Situation B ☐</td></tr>
</table>

<table>
<tr><th colspan="2">Question 4 Which situation is worse for you?</th></tr>
<tr><td>SITUATION A</td><td>SITUATION B</td></tr>
<tr><td>No difficulty with:
• The effects of glaucoma and its treatment
Quite a lot of difficulty with:
• Central and near vision
• Mobility
• Activities of daily living
• Local eye discomfort
Severe difficulty with:
• Lighting and glare</td><td>No difficulty with:
• Local eye discomfort
Some difficulty with:
• Central and near vision
• Mobility
• Activities of daily living
Quite a lot of difficulty with:
• Lighting and glare
Severe difficulty with:
• The effects of glaucoma and its treatments</td></tr>
<tr><td colspan="2">(Tick one box only)
Situation A ☐ Situation B ☐</td></tr>
</table>

Question 5 Which situation is worse for you?	
SITUATION A	SITUATION B
No difficulty with: • Central and near vision • Mobility **Quite a lot of difficulty** with: • Lighting and glare • Activities of daily living **Severe difficulty** with: • Local eye discomfort • The effects of glaucoma and its treatments	**Some difficulty** with: • Central and near vision • Local eye discomfort • The effects of glaucoma and its treatments **Quite a lot of difficulty** with: • Mobility **Severe difficulty** with: • Lighting and glare • Activities of daily living
(Tick one box only)	
Situation A ☐	**Situation B** ☐

Question 6 Which situation is worse for you?	
SITUATION A	SITUATION B
No difficulty with: • Lighting and glare **Some difficulty** with: • Mobility • The effects of glaucoma and its treatments **Quite a lot of difficulty** with: • Central and near vision • Activities of daily living **Severe difficulty** with: • Local eye discomfort	**No difficulty** with: • Mobility **Some difficulty** with: • Local eye discomfort **Quite a lot of difficulty** with: • Lighting and glare • The effects of glaucoma and its treatments **Severe difficulty** with: • Central and near vision • Activities of daily living
(Tick one box only)	
Situation A ☐	**Situation B** ☐

Question 7 Which situation is worse for you?	
SITUATION A	SITUATION B
Some difficulty with: • Central and near vision • Activities of daily living • Local eye discomfort • The effects of glaucoma and its treatments **Severe difficulty** with: • Lighting and glare • Mobility	**No difficulty** with: • Central and near vision • Lighting and glare • Local eye discomfort **Some difficulty** with: • Mobility **Quite a lot of difficulty** with: • Activities of daily living **Severe difficulty** with: • The effects of glaucoma and its treatments
(Tick one box only) **Situation A** ☐	**Situation B** ☐

Question 8 Which situation is worse for you?	
SITUATION A	SITUATION B
No difficulty with: • Central and near vision • Mobility • Activities of daily living **Some difficulty** with: • Lighting and glare **Quite a lot of difficulty** with: • The effects of glaucoma and its treatments **Severe difficulty** with: • Local eye discomfort	**No difficulty** with: • Local eye discomfort • The effects of glaucoma and its treatments **Some difficulty** with: • Mobility • Activities of daily living **Severe difficulty** with: • Central and near vision • Lighting and glare
(Tick one box only) **Situation A** ☐	**Situation B** ☐

Question 9 Which situation is worse for you?	
SITUATION A	SITUATION B
No difficulty with: • Lighting and glare • Mobility • Local eye discomfort **Some difficulty** with: • The effects of glaucoma and its treatments **Severe difficulty** with: • Central and near vision • Activities of daily living	**Some difficulty** with: • Central and near vision • Mobility • Activities of daily living **Quite a lot of difficulty** with: • Lighting and glare **Severe difficulty** with: • Local eye discomfort • The effects of glaucoma and its treatments
(Tick one box only)	
Situation A ☐	**Situation B** ☐

Question 10 Which situation is worse for you?	
SITUATION A	SITUATION B
No difficulty with: • Lighting and glare • Activities of daily living • Local eye discomfort **Quite a lot of difficulty** with: • Central and near vision **Severe difficulty** with: • Mobility • The effects of glaucoma and its treatments	**Some difficulty** with: • Lighting and glare • Mobility • Local eye discomfort • The effects of glaucoma and its treatments **Quite a lot of difficulty** with: • Activities of daily living **Severe difficulty** with: • Central and near vision
(Tick one box only)	
Situation A ☐	**Situation B** ☐

<table>
<tr><th colspan="2">Question 11 Which situation is worse for you?</th></tr>
<tr><td>SITUATION A</td><td>SITUATION B</td></tr>
<tr><td>Quite a lot of difficulty with:
Central and near vision
Lighting and glare
Mobility
Local eye discomfort
Severe difficulty with:
Activities of daily living
The effects of glaucoma and its treatments</td><td>No difficulty with:
Central and near vision
Lighting and glare
The effects of glaucoma and its treatments
Some difficulty with:
Activities of daily living
Severe difficulty with:
Mobility
Local eye discomfort</td></tr>
<tr><td colspan="2">(Tick one box only)
Situation A ☐ Situation B ☐</td></tr>
</table>

<table>
<tr><th colspan="2">Question 12 Which situation is worse for you?</th></tr>
<tr><td>SITUATION A</td><td>SITUATION B</td></tr>
<tr><td>No difficulty with:
Mobility
Local eye discomfort
Some difficulty with:
Central and near vision
Activities of daily living
Severe difficulty with:
Lighting and glare
The effects of glaucoma and its treatments</td><td>No difficulty with:
Central and near vision
Activities of daily living
Some difficulty with:
The effects of glaucoma and its treatments
Quite a lot of difficulty with:
Lighting and glare
Severe difficulty with:
Mobility
Local eye discomfort</td></tr>
<tr><td colspan="2">(Tick one box only)
Situation A ☐ Situation B ☐</td></tr>
</table>

Question 13 Which situation is worse for you?	
SITUATION A	SITUATION B
Some difficulty with: • Lighting and glare • Activities of daily living • The effects of glaucoma and its treatments **Quite a lot of difficulty** with: • Local eye discomfort **Severe difficulty** with: • Central and near vision • Mobility	**No difficulty** with: • Activities of daily living **Some difficulty** with: • Mobility **Quite a lot of difficulty** with: • Central and near vision • Lighting and glare **Severe difficulty** with: • Local eye discomfort • The effects of glaucoma and its treatments
(Tick one box only) **Situation A** ☐	**Situation B** ☐

Question 14 Which situation is worse for you?	
SITUATION A	SITUATION B
No difficulty with: • Activities of daily living • The effects of glaucoma and its treatments **Quite a lot of difficulty** with: • Mobility • Local eye discomfort **Severe difficulty** with: • Central and near vision • Lighting and glare	**No difficulty** with: • Lighting and glare • Mobility **Some difficulty** with: • The effects of glaucoma and its treatments **Quite a lot of difficulty** with: • Central and near vision **Severe difficulty** with: • Activities of daily living • Local eye discomfort
(Tick one box only) **Situation A** ☐	**Situation B** ☐

Question 15 Which situation is worse for you?	
SITUATION A	SITUATION B
No difficulty with: • Mobility • The effects of glaucoma and its treatments **Some difficulty** with: • Local eye discomfort **Quite a lot of difficulty** with: • Activities of daily living **Severe difficulty** with: • Central and near vision • Lighting and glare	**No difficulty** with: • Central and near vision **Some difficulty** with: • Lighting and glare • Activities of daily living **Quite a lot of difficulty** with: • Local eye discomfort • The effects of glaucoma and its treatments **Severe difficulty** with: • Mobility
(Tick one box only) **Situation A** ☐	**Situation B** ☐

Section 2 – About You

Finally, could you please provide a few details about yourself, to help us understand the results? **Again, all answers are completely confidential.**

1. What is the highest level of education completed?

(Please tick one box)

Secondary school ☐

College ☐

University ☐

None ☐

Other *(please specify)* ☐

2. Could you please provide an estimate of your annual household income from all sources (before tax and including your partner/spouse)?

(Please tick one box)

Less than £6,000	
£6,000 to £10,000	
£10,001 to £15,000	
£15,001 to £20,000	
£20,001 to £25,000	
£25,001 to £30,000	
£30,001 to £35,000	
£35,001 and greater	

Are there any comments that you would like to make regarding the questionnaire?

____

____

____

Would you please say about how long it took you to complete the whole questionnaire ☐

Thank you for taking time to complete this questionnaire.
Please post it back to us in the enclosed pre-paid envelope.

TIME AND TRAVEL QUESTIONNAIRE

Study Number

TAGS

Treatment of Advanced Glaucoma Study

A multicentre randomised controlled trial comparing primary medical treatment with primary trabeculectomy for people with newly diagnosed advanced glaucoma

Thank you for helping us with our research.
We would be very grateful if you could complete this questionnaire

CONFIDENTIAL

TIME AND TRAVEL QUESTIONNAIRE

This questionnaire will help us find out how much it costs **YOU** to use health services. We wish to know how much money and time were spent by you and any companion in attending health care appointments or being admitted to hospital.

Please answer all the questions about your **most recent admission to hospital** (column A) first, then about your **most recent outpatient appointment** (column B), then about your **most recent GP appointment** (column C), and then about your most recent visit to a **community optician or optometrist** (column D). These attendances could be for any reason, and do not need to be for your glaucoma. Your last visit may have been a long time ago and we understand that you may not remember the exact details. We would really appreciate your best guess.

If you have not attended the services mentioned in this questionnaire, please tick the "N/A" box and move on to the next column of questions.

Q1: Please write the date you completed this questionnaire:

D	D	M	M	Y	Y

	A	B	C	D
	Your most recent **hospital inpatient** admission	Your most recent **outpatient** consultation	Your most recent **GP appointment**	Your most recent visit to a **community optician or optometrist**
1. Not applicable (N/A)	N/A ☐ If you have **not** been admitted as an inpatient, go directly to column B (outpatient consultation) ⇨	N/A ☐ If you have **not** been to the hospital outpatients, go directly to column C (GP appointment) ⇨	N/A ☐ If you have **not** been to the GP, go directly to column D (community optician or optometrist appointment) ⇨	N/A ☐ If you have **not** been to the community optician or optometrist, you have now completed the questionnaire. **Please return to the address on the final page.**
2. How did you travel? If you used more than one form of transport, please indicate the way you travelled for the main (in terms of distance) part of your journey. *(Please tick the appropriate box)*	Train ☐ Bus/Tram ☐ Private Car ☐ Taxi ☐ Hospital Car ☐ Ambulance ☐ Walk ☐ Cycle ☐ Other *(please specify)* ☐ ______	Train ☐ Bus/Tram ☐ Private Car ☐ Taxi ☐ Hospital Car ☐ Ambulance ☐ Walk ☐ Cycle ☐ Other *(please specify)* ☐ ______	Train ☐ Bus/Tram ☐ Private Car ☐ Taxi ☐ Hospital Car ☐ Ambulance ☐ Walk ☐ Cycle ☐ Other *(please specify)* ☐ ______	Train ☐ Bus/tram ☐ Private car ☐ Taxi ☐ Hospital Car ☐ Ambulance ☐ Walk ☐ Cycle ☐ Other *(please specify)* ☐ ______
3. How many miles did you travel one-way? *(Please give your best guess about the distance travelled to the place of your appointment)*	☐ Miles	☐ Miles	☐ Miles	☐ Miles

	Your most recent **hospital inpatient** admission	Your most recent **outpatient** consultation	Your most recent **GP appointment**	Your most recent visit to a **community optician or optometrist**
4. If you travelled by taxi or public transport, what was the total cost of the return fare(s)? *(Please state '£0' if no fares were incurred)*	£ ☐ . ☐	£ ☐ . ☐	£ ☐ . ☐	£ ☐ . ☐
5. If you travelled by car (or similar), how much did you or your companion have to pay in parking fees? *(Please state '£0' if no fares were incurred)*	£ ☐ . ☐	£ ☐ . ☐	£ ☐ . ☐	£ ☐ . ☐
6. How long did you spend away from doing other things to attend your appointment? *(Please include time travelling and time at the appointment or admission itself)*	Days ☐ Hours ☐	Hours ☐ Minutes ☐	Hours ☐ Minutes ☐	Hours ☐ Minutes ☐
7. If you were not attending your appointment, what would you have otherwise been doing as your main activity? *(Please tick the box that best applies)*	Paid Work ☐ Homemaker ☐ Childcare ☐ Caring for a friend/relative ☐ Retired ☐ Full-time education ☐ Unemployed ☐ Voluntary work ☐ Leisure Activities ☐ Other *(please specify)* ☐	Paid Work ☐ Homemaker ☐ Childcare ☐ Caring for a friend/relative ☐ Retired ☐ Full-time education ☐ Unemployed ☐ Voluntary work ☐ Leisure Activities ☐ Other *(please specify)* ☐	Paid Work ☐ Homemaker ☐ Childcare ☐ Caring for a friend/relative ☐ Retired ☐ Full-time education ☐ Unemployed ☐ Voluntary work ☐ Leisure Activities ☐ Other *(please specify)* ☐	Paid Work ☐ Homemaker ☐ Childcare ☐ Caring for a friend/relative ☐ Retired ☐ Full-time education ☐ Unemployed ☐ Voluntary work ☐ Leisure activities ☐ Other *(please specify)* ☐

	Your most recent **hospital inpatient** admission	Your most recent **outpatient** consultation	Your most recent **GP appointment**	Your most recent visit to a **community optician or optometrist**
8. Did someone accompany you to your appointment? *(Please tick either "no" or "yes")*	No ☐ Please continue to column B – outpatient consultation Yes ☐ Please continue below	No ☐ Please continue to column C – GP appointment Yes ☐ Please continue below	No ☐ Please continue to column D – Optician appointment Yes ☐ Please continue below	No ☐ Please return completed questionnaire Yes ☐ Please continue below
9. If someone accompanied you to your appointment, what would this person otherwise have been doing, had they not gone with you? *(Please tick the box that best applies)*	Paid work ☐ Homemaker ☐ Childcare ☐ Caring for a friend/relative ☐ Retired ☐ Full-time education ☐ Unemployed ☐ Voluntary work ☐ Leisure Activities ☐ Other *(please specify)* ☐ ☐	Paid work ☐ Homemaker ☐ Childcare ☐ Caring for a friend/relative ☐ Retired ☐ Full-time education ☐ Unemployed ☐ Voluntary work ☐ Leisure Activities ☐ Other *(please specify)* ☐ ☐	Paid work ☐ Homemaker ☐ Childcare ☐ Caring for a friend/relative ☐ Retired ☐ Full-time education ☐ Unemployed ☐ Voluntary work ☐ Leisure Activities ☐ Other *(please specify)* ☐ ☐	Paid work ☐ Homemaker ☐ Childcare ☐ Caring for a friend/relative ☐ Retired ☐ Full-time education ☐ Unemployed ☐ Voluntary work ☐ Leisure activities ☐ Other *(please specify)* ☐ ☐
10. How long did your companion spend away from doing other things to accompany you? *(Please include time travelling and time at the appointment or admission with you)*	Days ☐ Hours ☐	Hours ☐ Minutes ☐	Hours ☐ Minutes ☐	Hours ☐ Minutes ☐
	Please go to column B (*page 3*) ⇨	Please go to column C (*page 3*) ⇨	Please go to column D (*page 3*) ⇨	

THANK YOU

Once you have completed the form, please return it in the pre-paid envelope provided or to the address below:

Thank you very much for your time and patience in filling in this questionnaire.

The information you have given us will be extremely useful in helping us carry out our research into treatments for glaucoma.

It will be treated with the strictest confidence and kept securely.

If you would like any further information or have any queries about the study, please contact:

TAGS Study Office
Health Services Research Unit
University of Aberdeen
3rd Floor, Health Sciences Building
Foresterhill
Aberdeen
AB25 2ZD
UK

Telephone: 01224 438196
Email: tags@abdn.ac.uk
Website: www.tagsstudy.co.uk

The questionnaires are processed in Aberdeen at the
Centre for Health Care Randomised Trials (CHaRT), Health Services Research Unit,
Health Sciences Building, Foresterhill, Aberdeen, AB25 2ZD, UK.