

# PREPARED

© 1998 University of South Australia & Adelaide Research & Innovation

## Office use only

ID No.

Hospital

## PATIENT QUESTIONNAIRE

### SECTION 1: QUESTIONS ABOUT YOU, THE PATIENT

1. Name of Hospital Ward from which you were discharged .....
  2. Home post code .....
  3. Today's Date                    /        / 20\_\_\_\_\_
- Please circle*
4. Your gender                    Male                    Female
  5. Your date of birth            /        /
  6. What was the reason for your last admission to hospital? .....
  - .....
  7. What date and day of the week were you discharged from hospital?  
(e.g. Thursday, 26<sup>th</sup> October) .....
  8. What time of the day were you discharged from hospital (include am or pm)? .....

#### Instrument Authors

Prof Karen Grimmer-Somers  
International Centre for Allied Health Evidence  
University of South Australia  
Email: iCAHE@unisa.edu.au

International Centre for  
Allied Health Evidence



Assoc. Prof. John Moss  
Department of Public Health  
University of Adelaide (operating through Adelaide  
Research & Innovation)  
Email: john.moss@adelaide.edu.au

## WE ARE INTERESTED IN HOW MUCH INFORMATION YOU RECEIVED IN HOSPITAL TO PREPARE YOU FOR COPING AT HOME

### SECTION II: WHILE YOU WERE IN HOSPITAL:-

1	How much information did you receive about the medications that you were to take home? <i>Please tick only one box</i>	As much as I needed	<input type="radio"/>
		Some, but not enough	<input type="radio"/>
		None	<input type="radio"/>
		Not taking <b>any</b> medications	<input type="radio"/>
2	How much information did you receive about the side effects of the medications that you were to take at home? <i>Please tick only one box</i>	As much as I needed	<input type="radio"/>
		Some, but not enough	<input type="radio"/>
		None	<input type="radio"/>
		Not taking <b>any</b> medications	<input type="radio"/>
3	Were you given <b>written</b> instructions about your medications? <i>Please tick only one box</i>	Yes	<input type="radio"/>
		No	<input type="radio"/>
		Not taking <b>any</b> medications	<input type="radio"/>
4	If <b>YES</b> did someone spend time explaining the written instructions? <i>Please tick</i>	Yes	<input type="radio"/>
		No	<input type="radio"/>
5	How much information did you receive on how you would <b>manage your usual activities</b> when you went home? (e.g. shopping, showering, bathing etc) <i>Please tick only one box</i>	As much as I needed	<input type="radio"/>
		Some, but not enough	<input type="radio"/>
		None	<input type="radio"/>
6	How much information did you receive on <b>community services</b> you might use once you went home? (e.g. Domiciliary Care, District Nurse, Meals on Wheels etc) <i>Please tick only one box</i>	As much as I needed	<input type="radio"/>
		Some, but not enough	<input type="radio"/>
		None	<input type="radio"/>
		No services needed	<input type="radio"/>
7	How much information did you receive on <b>equipment</b> you might need once you went home? (e.g. rails, shower chair, walking aids etc) <i>Please tick only one box</i>	As much as I needed	<input type="radio"/>
		Some, but not enough	<input type="radio"/>
		None	<input type="radio"/>
		No equipment needed	<input type="radio"/>

**SECTION III: BEFORE YOU WERE DISCHARGED FROM HOSPITAL:-**

**1** Did anyone arrange community services for you to use at home? (e.g. Domiciliary Care, District Nurse, Meals on Wheels etc)

Yes  No

*Please tick only one box*

No-one needed to:-   
*Services were already in place*

**1a.** No-one needed to:   
*No services needed*

.....

If you answered **YES**, have the services commenced? *or*  
 If you answered **SERVICES WERE ALREADY IN PLACE**, have the services recommenced?

Yes  No

.....

**1b.** If **NO**, why? .....

.....

**2.** Did anyone arrange equipment for you?

Yes  No

*Please tick only one box*

No-one needed to:-   
*Equipment already in place*

**2a.** No-one needed to:   
*No equipment needed*

.....

If **YES**, do you have this equipment now?

Yes  No

.....

**2b.** If **NO**, why? .....

.....

**3.** Was there any other information you would have liked while you were in hospital, to prepare you for coping at home?

Yes  No

*Please tick one box only*

**3a.** Please tell us more about this

.....

.....

.....

**SECTION IV: AFTER YOU WERE TOLD YOU COULD LEAVE HOSPITAL:-**

- 1 How confident did you feel about managing at home?  
*Please tick only one box*
- |               |                       |
|---------------|-----------------------|
| Confident     | <input type="radio"/> |
| Unsure        | <input type="radio"/> |
| Not confident | <input type="radio"/> |

Please tell us more about this

.....

.....

.....

2. Were there any delays on the day you left hospital?
- |     |                       |
|-----|-----------------------|
| Yes | <input type="radio"/> |
| No  | <input type="radio"/> |

3. If **YES**, what caused the delay?  
*Please tick as many as you wish*
- |             |                       |
|-------------|-----------------------|
| Transport   | <input type="radio"/> |
| Medications | <input type="radio"/> |
| Don't know  | <input type="radio"/> |
| Other       | <input type="radio"/> |
| -----       |                       |
- Please indicate*

**SECTION V: NOW THAT YOU HAVE BEEN OUT OF HOSPITAL FOR A WHILE:-**

- 1 Has anything been worrying you about managing at home?  
*Please tick*
- |     |                       |
|-----|-----------------------|
| Yes | <input type="radio"/> |
| No  | <input type="radio"/> |

1a. Please tell us more about this

.....

.....

.....

- 2 Has anything been done to deal with your worries?  
*Please tick*
- |     |                       |
|-----|-----------------------|
| Yes | <input type="radio"/> |
| No  | <input type="radio"/> |

2a. Please tell us more about this .....

.....

3. Are you a carer for someone else? Yes   
 For whom? (Spouse, child, other relative, friend, other) No   
*Please circle*

4. Have any unexpected problems occurred since you have been home? Yes   
*Please tick* No

4a. Please tell us more about this  
 .....  
 .....  
 .....

5. If you have already received community services, have they met your needs? Yes   
*Please tick* No

5a. Please tell us more about this  
 .....  
 .....  
 .....

6. If equipment has already been provided, has it met your needs? Yes   
*Please tick* No

6a. Please tell us more about this  
 .....  
 .....  
 .....

**SECTION VI: IN THE FIRST WEEK AFTER YOU LEFT HOSPITAL:-**

**1** How many times did you see:- *(Please put the number of times on **each** line)*

Your local doctor	_____	Your specialist doctor	_____
Physiotherapist	_____	Chemist	_____
Occupational Therapist	_____	Meals on Wheels	_____
Domiciliary Care	_____	Other health professionals	_____
District Nurse	_____	Any other people who have helped you	_____
Hospital outpatient/ Emergency clinic	_____	<i>Please write who they were on the line below</i>	

**2** Did you receive any of the following services?

<i>Please tick</i>	Home modifications	<input type="radio"/>
	Assistance with shopping	<input type="radio"/>
	House cleaning	<input type="radio"/>
<i>Please indicate</i>	Others	<input type="radio"/>
	_____	

**3** Have you spent any extra money as a result of your visit to hospital? *(such as taxi fares, petrol, etc)*

<i>Please tick</i>	Yes	<input type="radio"/>
	No	<input type="radio"/>

**3a.** If so, what were these costs approximately?

Taxi fares	\$	_____	Petrol	\$	_____
Extra shopping	\$	_____	Gap payments for health services	\$	_____
Extra chemist costs	\$	_____	Private Health Services	\$	_____
Other		_____	<i>Please write what it was on the line below</i>		
			_____		

**4** Have you used any extra electricity?

<i>Please tick</i>	Yes	<input type="radio"/>
	No	<input type="radio"/>

**4a.** If **YES**, what have you used it for?

.....

.....

**SECTION VII: LOOKING BACK TO THE TIME YOU LEFT HOSPITAL:**

- 1 Overall, how prepared did you feel for returning home? Very prepared   
*Please tick* Moderately prepared   
Unprepared

2. Were there any particular aspects of your preparation for discharge whilst in hospital, that you would like to comment further on?

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

3. Were there any particular aspects of your care after leaving hospital, that you would like to comment further on?

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

**There is also space for you to write on the back of this page if you require**





**SECTION VIII: THIS SHEET WILL BE REMOVED AND USED AS A CONSENT FORM FOR US TO CONTACT YOUR DOCTOR.**

1 When you were in hospital, what were you told to tell your usual doctor (GP) when you saw him/her?  
 .....  
 .....  
 .....

2 Who is your usual doctor (GP) and what is his/her address?  
 .....  
 .....  
 .....

3 Do you usually see any other doctors (GP's) Yes   
*Please tick* No   
 If YES, How many .....

4 Do you consent to us contacting your usual GP about his/her views about your recent discharge from hospital? Yes   
*Please tick* No

If YES, please print your name and sign

PRINT YOUR NAME .....

SIGNATURE .....

**THANK YOU FOR TAKING THE TIME TO COMPLETE THIS QUESTIONNAIRE**

**PLEASE PUT IT IN THE ENVELOPE PROVIDED AND RETURN IT TO US AS SOON AS POSSIBLE**