UK-ROX questionnaire

Completing this questionnaire

Today's date ☐☐ / ☐☐ / ☐☐☐☐

Did you complete questionnaire (please tick)

- Alone ❑
- With help ❑
- Someone else completed it for you (e.g. family member, friend, carer) ❑

I do not wish to complete this questionnaire *(please tick)* ❑

Please return your questionnaire in the stamped, addressed envelope provided

EQ-5D-5L

Health

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

MOBILITY

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

SELF-CARE

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

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

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

PAIN / DISCOMFORT

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

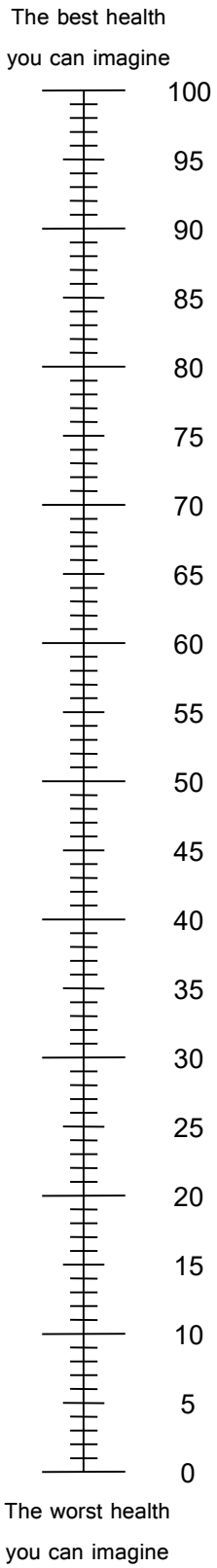
ANXIETY / DEPRESSION

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

Health

- 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.
- Please mark an X on the scale to indicate how your health is TODAY.
- Now, write the number you marked on the scale in the box below.

YOUR HEALTH TODAY = ☐



Health services

These questions will help us understand the care you needed after leaving the hospital.

Please answer the multiple choice questions by putting a ✓ in **ONE** box for each question.

Q1 Where are you now?

- ❑ At home (your own home, or a relative's home)
- ❑ In residential care (e.g. nursing home, hospice)
- ❑ In short-term rehabilitation
- ❑ In long-term rehabilitation
- ❑ In hospital
- ❑ Other (please specify):

Q2 Hospital stays

Since you left hospital on
have you stayed overnight in hospital for any reason?

No – *Please go to Q3*

Yes – *Please give details about the number of stays below*

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

	Number of nights		1 – 3 nights	4 – 10 nights	11 or more nights	Did you spend any part of your stay in intensive care?
1st stay		*Or tick...*	❑	❑	❑	❑
2nd stay		*Or tick...*	❑	❑	❑	❑
3rd stay		*Or tick...*	❑	❑	❑	❑
4th stay*		*Or tick...*	❑	❑	❑	❑

**If you have stayed in hospital more than 4 times, please could you provide information on these further hospital stays in Q7 of the questionnaire.*

Health services

Q3 Visits to hospital outpatients

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

Since you left hospital on
have you visited hospital outpatients about ANY ASPECT of your health?

❑ **No** – *Please go to Q4*

❑ **Yes** – *Please give details about the number of outpatients visit(s) below*

Number of visits		1 – 3 visits	4 – 10 visits	11 or more visits
☐	*Or tick...*	❑	❑	❑

Q4 Visits to health care providers

Since you left the hospital on
have you visited any of the health care providers listed below about ANY ASPECT of your health?

❑ **No** – *Please go to Q5*

❑ **Yes** – *Please give details about the number of visits below*

For EACH PROVIDER please answer the following:

Did you visit this provider?	(please tick)	Number of visits		1 – 3 visits	4 – 10 visits	11 or more visits
GP	❑	☐	*Or tick...*	❑	❑	❑
Nurse at your GP clinic	❑	☐	*Or tick...*	❑	❑	❑
Nurse at hospital or elsewhere	❑	☐	*Or tick...*	❑	❑	❑
Health visitor	❑	☐	*Or tick...*	❑	❑	❑
Critical care follow-up clinic	❑	☐	*Or tick...*	❑	❑	❑

Health services

Q5 Visits to your home by health care providers

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

❑ **No** – *Please go to Q6*

❑ **Yes** – *Please give details about the number of visits below*

For EACH PROVIDER please answer the following:

Were you visited at home by this provider?	(please tick)	Number of visits		1 – 3 visits	4 – 10 visits	11 or more visits
GP	❑		*Or tick...*	❑	❑	❑
Nurse from your GP clinic	❑		*Or tick...*	❑	❑	❑
Health visitor or district nurse	❑		*Or tick...*	❑	❑	❑

Q6 Visits to other service providers

Since you left hospital on
have had contact (either visits to the provider or home visits) with any of the following service providers about ANY ASPECT of your health?

❑ **No** – *Please go to Q7*

❑ **Yes** – *Please give details about the number of visits below*

For EACH PROVIDER please answer the following:

Have you had contact with any of these providers?	(please tick)	Number of visits		1 – 3 visits	4 – 10 visits	11 or more visits
Occupational therapist	❑		*Or tick…*	❑	❑	❑
Speech and Language therapist	❑		*Or tick...*	❑	❑	❑
Physiotherapist	❑		*Or tick...*	❑	❑	❑
Psychiatrist	❑		*Or tick...*	❑	❑	❑
Mental health or Psychiatric nurse	❑		*Or tick...*	❑	❑	❑
Clinical Psychologist	❑		*Or tick...*	❑	❑	❑
Counsellor	❑		*Or tick...*	❑	❑	❑

Health services

Q7 Other services not listed so far

Since you left hospital on
have you had further hospital stays or used any other health care services for ANY ASPECT of your health that you haven't included previously?

❑ **No** – *Please go to Q8*

❑ **Yes** – *Please give details about the number of visits below*

For EACH PROVIDER please answer the following:

Type of service provider	Number of visits	Reason

Q8 Your views are important to us. Please feel free to provide any other comments you have in the box below.

Thank you for your time