Healthcare Contacts Form

TO BE COMPLETED FROM DIRECT INTERVIEW WITH A PATIENT AT 3, 6, 9 AND 12 MONTHS FROM DATE OF RANDOMISATION

Trial Number: ☐☐☐☐ | Initials: *First, Middle, Last* ☐☐☐ | Site Name: _____

Section 1 - Visit Details

Timepoint (months) ◯ 3m ◯ 6m ◯ 9m ◯ 12m | Date of trial appointment D D - M M M - Y Y Y Y

Section 2 - Covid-19 Details

Since your last trial appointment have you had a test for Covid-19? ◯ No ◯ Yes

What was the outcome of the test? ◯ Negative ◯ Positive

Section 3 - NHS Primary Care Visits

In this section we ask you about NHS healthcare you might have accessed

Since your last trial appointment have you attended the following community NHS services for symptoms related to your COPD? (please do not include any sessions or treatments that you attended as part of the study).

◯ No ◯ Yes

If yes complete below section (if you haven't used a service enter '0'). If no please go to section 4.

NHS Service	Number of Visits
Your GP or another GP	☐☐
Practice Nurse	☐☐
Physiotherapist	☐☐
Psychologist	☐☐
Counsellor	☐☐
Respiratory Nurse	☐☐
District Nurse	☐☐
Acupuncturist	☐☐
Other, please write _____	☐☐

Please continue to next page.

Trial Number: | Initials: *First, Middle, Last*

Section 4 - A&E Visits

Since your last trial appointment, have you visited an accident and emergency department because symptoms related to your COPD?

◯ No ◯ Yes

If yes, please complete the section below for each visit. If no please go to section 5.

How many times did you visit A&E?

Start date of first A&E visit: D D - M M M - Y Y Y Y

Did you have any of the following procedures? If none please write '0'.

Investigations	
	Number performed
X-ray	
CT Scan	
Other, please write _____	

Start date of second A&E visit: D D - M M M - Y Y Y Y

Did you have any of the following procedures? If none please write '0'.

Investigations	
	Number performed
X-ray	
CT Scan	
Other, please write _____	

Start date of third A&E visit: D D - M M M - Y Y Y Y

Did you have any of the following procedures? If none please write '0'.

Please continue to next page.

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Section 5 - Hospital Admissions

Since the last time you were seen at a trial appointment, have you been admitted to hospital? ◯ No ◯ Yes

If yes, please complete the section below for each visit. If no please go to section 6.

How many times were you admitted to hospital? ☐

1st Hospital Admission

Type of admission *(please tick one):* ◯ Elective ◯ Emergency

Primary reason for admission: *(refer to coded table 1 on pg. 9)* ☐ | If other please specify _____

Date of hospital admission D D - M M M - Y Y Y Y

Number of days you spent in hospital ☐☐☐

Location of Patient During Admission (put '0' if patient did not stay on the relevant ward type)	
	Length of Stay (Days)
General Ward (Level 0)	☐☐☐
Acute (Level 1)	☐☐☐
HDU (Level 2)	☐☐☐
ITU (Level 3)	☐☐☐

Did you have any of the following procedures? If none please write '0'.

Investigations/procedure	
	Number performed
X-ray	☐
CT scan	☐
Oxygen therapy	☐
Nebuliser	☐
Non-invasive ventilation	☐
Other, please write _____	☐

Please continue to next page.

Trial Number: ☐☐☐☐ | Initials: *First, Middle, Last* ☐☐☐

Section 5 - Hospital Admissions Continued

2nd Hospital Admission

Type of admission *(please tick one):* ◯ Elective ◯ Emergency

Primary reason for admission: *(refer to coded table 1 on pg. 9)* ☐ | If other please specify _____

Date of hospital admission D D - M M M - Y Y Y Y

Number of days you spent in hospital ☐☐☐

Location of Patient During Admission (put '0' if patient did not stay on the relevant ward type)	
	Length of Stay (Days)
General Ward (Level 0)	☐☐☐
Acute (Level 1)	☐☐☐
HDU (Level 2)	☐☐☐
ITU (Level 3)	☐☐☐

Did you have any of the following procedures? If none please write '0'.

Investigations/procedure	
	Number performed
X-ray	☐
CT scan	☐
Oxygen therapy	☐
Nebuliser	☐
Non-invasive ventilation	☐
Other, please write _____	☐

Please continue to next page.

Trial Number: ☐☐☐☐ Initials: *First, Middle, Last* ☐☐☐

Section 5 - Hospital Admissions Continued

3rd Hospital Admission

Type of admission *(please tick one):* ◯ Elective ◯ Emergency

Primary reason for admission: *(refer to coded table 1 on pg. 9)* ☐ If other please specify _____

Date of hospital admission D D - M M M - Y Y Y Y

Number of days you spent in hospital ☐☐☐

Location of Patient During Admission (put '0' if patient did not stay on the relevant ward type)	
	Length of Stay (Days)
General Ward (Level 0)	☐☐☐
Acute (Level 1)	☐☐☐
HDU (Level 2)	☐☐☐
ITU (Level 3)	☐☐☐

Did you have any of the following procedures? If none please write '0'.

Investigations/procedure	
	Number performed
X-ray	☐
CT scan	☐
Oxygen therapy	☐
Nebuliser	☐
Non-invasive ventilation	☐
Other, please write _____	☐

Please continue to next page.

Trial Number: ☐☐☐☐ Initials: *First, Middle, Last* ☐☐☐

Section 6 - Private Healthcare Costs

Since your last trial appointment did you use any healthcare services **you paid for yourself or paid by friends/relatives; or that were paid for by private insurance** for symptoms related to your COPD?

◯ No ◯ Yes

If yes complete below, if no go to next question

Please do not include any treatment paid for by the NHS. Please round the amounts to the nearest pound. If you have not used a private healthcare service please write 0 in number of visits. If you do not know the actual cost please give us your best estimate of the costs. If paid for by insurance please tick box in relevant row(s)

Private Healthcare Costs Table

	Number of visits	Cost paid by you or friends/relatives	Paid for by insurance?
Private physiotherapist	☐☐	£☐☐☐☐	☐
Private hospital doctor	☐☐	£☐☐☐☐	☐
Private psychologist	☐☐	£☐☐☐☐	☐
Private counsellor	☐☐	£☐☐☐☐	☐
Private acupuncturist	☐☐	£☐☐☐☐	☐
Private GP	☐☐	£☐☐☐☐	☐
Other, please write	☐☐	£☐☐☐☐	☐

Since your last trial appointment have you been admitted to a private hospital because of symptoms related to your COPD? ◯ No ◯ Yes

If yes complete below, if no go to section 7

If yes, please write in the number of days in hospital ☐☐

How was this paid for? ◯ By you or friends/relatives ◯ By private insurance

If paid by you or paid by friends/relatives, what were the total costs paid? *To the nearest pound. If you don't know the actual cost please give your best estimate of cost.*

£ ☐☐☐☐☐

Please continue to next page.

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Section 7 - Equipment Purchase

Since your last trial appointment have you or friends/relatives bought or has the NHS provided items such as a nebuliser machine, flutter device, Aerosure, Aerobika, or any other products or equipment because of your symptoms related to your COPD?

◯ No ◯ Yes

If yes complete below, if no go to section 8

Please estimate cost to the nearest pound. If equipment was provided by the NHS please tick the box in the relevant row (a cost isn't required). If you or a family member/friend paid please provide the cost below. If you do not know the actual cost please give us your best estimate of the costs.

Equipment Puchased			
	Item	Cost paid for by you or family/friends	Provided by NHS
1	_____	£☐☐☐☐☐	☐
2	_____	£☐☐☐☐☐	☐
3	_____	£☐☐☐☐☐	☐
4	_____	£☐☐☐☐☐	☐
5	_____	£☐☐☐☐☐	☐

Section 8 - About your work

Are you currently in paid employment or have you been employed since your last appointment? ◯ No ◯ Yes

If you said that you are not working at the moment please tell us which of the following best describes your current situation:

- ◯ Looking for work
- ◯ Not able to work due to pain from surgery
- ◯ Permanently unable to work (for reasons other than pain from surgery)
- ◯ Retired
- ◯ Looking after home or family
- ◯ Other, please specify: _____

If you haven't worked since joining trial and are not intending to return to work please go to section 9

Have you stopped working since your last trial appointment? ◯ No ◯ Yes

If yes, when did you stop working? D D - M M M - Y Y Y Y

Have you returned to work since your last trial appointment? ◯ No ◯ Yes

If yes, when did you start working again? D D - M M M - Y Y Y Y

Please indicate whether employment is full or part time ◯ Full-time ◯ Part-time

If part-time please indicate number of hours worked per week ☐☐

What is the name and title of your job?

Job name/title _____

Industry _____

Please continue to next page.

Trial Number: ☐☐☐☐ | Initials: *First, Middle, Last* ☐☐☐

Section 8 - About your work continued

Since your last trial appointment have you needed to take time off work because of symptoms related to your COPD? ◯ No ◯ Yes

If yes provide number of days taken off work due to symptoms related to your COPD ☐☐

Since your last trial appointment have your hours of employment altered because of symptoms related to your COPD?
◯ No ◯ Yes, increased ◯ Yes, decreased

If yes, by how many hours per week has your employment changed? ☐☐

When did this change occur? *(please write date)* D D - M M M - Y Y Y Y

Since your last trial appointment have you been restricted in what you can do at work due to symptoms related to your COPD?
◯ No ◯ Yes

If yes, please provide details of what ways your work has been affected: *(tick all that apply)*
- ◯ I have been able to do less work
- ◯ I have needed additional help from others
- ◯ I have had to change roles
- ◯ Other, please specify: _____

Section 9 - Activities

Are you a main carer for a relative/friend? ◯ No ◯ Yes

If yes, do you care for relative/friend full or part time? ◯ Full time ◯ Part time

If you care part time how much time do you spend caring each week on average? *Please write number of hours* ☐☐

If yes, is this paid or unpaid? ◯ Paid ◯ Unpaid

Since your last trial appointment have symptoms related to your COPD stopped you doing your normal activities (other than paid work)?
◯ No ◯ Yes

If yes complete below, if no go to section 10

Please tick any activities that have been affected and enter the total number of days in which symptoms related to your COPD stopped you getting on with your normal activities.

Activities Table

	Has been affected	Number of days affected
Education	◯ No ◯ Yes	☐☐☐
Housework	◯ No ◯ Yes	☐☐☐
Leisure	◯ No ◯ Yes	☐☐☐
Caring for a friend/relative	◯ No ◯ Yes	☐☐☐

Section 10 - Willing to continue

Has the patient confirmed willingness to continue?	◯ No	◯ Yes

If no please complete trial exit/change of status form

Section 11 - Form Completion

Completed by (name):	Signed:	Date Completed:
		D D - M M M - Y Y Y Y

Principal Investigator Name:	Principal Investigator Signature:	Date Completed:
		D D - M M M - Y Y Y Y

Coded Table 1	
1	Infective exacerbation COPD
2	Non-infective exacerbation COPD
3	Pleural effusion
4	Pneumonia
5	respiratory failure
6	ARDS
7	DVT/PE
8	Chest pain - angina
9	Abdominal pain
10	Deterioration in overall condition
11	Acid reflux
12	Constipation
13	Other, please specify