



Early Rib Analgesia with SERratus: ERASER Trial
 A Pragmatic Randomised Control Trial Evaluating the Clinical and Cost-Effectiveness of Serratus Anterior Plane Block with Catheter Insertion compared to Usual Care in Patients with Multiple Rib Fractures

30 DAY FOLLOW UP FORM

This trial uses eCRF only, all data should be entered onto <https://bctu-redcap.bham.ac.uk> This form illustrates data being collected for follow up.

Section 1 - PARTICIPANT DETAILS

Trial no: <input type="text"/>	Partial date of birth: <i>e.g. 31Jan2017</i> <input type="text"/>	Site ID: <input type="text"/>
Date of assessment: <i>e.g. 31Jan2017</i> <input type="text"/>	Status: <i>Select one</i> <input type="radio"/> Alive (continue to next item) <input type="radio"/> Deceased (<i>complete change of status form</i>)	

Section 2 - SERIOUS ADVERSE EVENTS

Did the participant experience any protocol defined expected SAE's during their admission: No Yes - please provide expected SAE ID

Expected SAE ID:

Details of SAE:

Section 3 - Charleson Comorbidity Index

Myocardial infarction: <i>Select one</i>	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown
Congestive heart failure: <i>Select one</i>	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown
Cerebrovascular disease: <i>Select one</i>	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown
Dementia <i>Select one</i>	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown
COPD: <i>Select one</i>	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown
Connective tissue disease: <i>Select one</i>	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown
Peptic ulcer disease: <i>Select one</i>	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown
Liver disease: <i>Select one</i>	<input type="radio"/> None <input type="radio"/> Mild <input type="radio"/> Moderate to severe <input type="radio"/> Unknown
Diabetes mellitus: <i>Select one</i>	<input type="radio"/> None <input type="radio"/> Without end-organ damage <input type="radio"/> With end-organ damage <input type="radio"/> Unknown
Hemiplegia or paraplegia: <i>Select one</i>	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown
Chronic kidney disease: <i>Select one</i>	<input type="radio"/> None <input type="radio"/> Mild <input type="radio"/> Moderate to severe <input type="radio"/> Unknown
Solid tumour: <i>Select one</i>	<input type="radio"/> None <input type="radio"/> Localised <input type="radio"/> Metastatic <input type="radio"/> Unknown
Leukaemia: <i>Select one</i>	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown
Lymphoma: <i>Select one</i>	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown
AIDS: <i>Select one</i>	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown

Section 4 - USE OF HEALTH CARE RESOURCES

1. In the last 1 months, please tell us the number of times you have seen your family doctor or other health care professional who is attached to your doctor's practice for your rib problem?

	Number of times in GP surgery	Number of times at home
Your GP or another GP	-- --	-- --
Practice nurse	-- --	-- --
District nurse	-- --	-- --
Physiotherapist	-- --	-- --
Psychologist	-- --	-- --
Counsellor	-- --	-- --
Acupuncturist	-- --	-- --
Chiropractor	-- --	-- --
Other, please specify all:	-- --	-- --

2. In the last 1 months, please tell us the number of times you have seen a health care professional(s), either in an outpatient NHS service or outpatient private care facility for your rib problem?

	Number of times in the NHS	Number of times privately	Cost of private treatment
Doctor	-- --	-- --	£
Nurse	-- --	-- --	£
Physiotherapist	-- --	-- --	£
Psychologist	-- --	-- --	£
Acupuncturist	-- --	-- --	£
Chiropractor	-- --	-- --	£
Other, please specify all:	-- --	-- --	£

3. In the last 1 months, please tell us if you have been prescribed any medicines (e.g. painkillers) to help your rib problem?

	Name(s) of medication	Number of prescriptions in the last 3 months
Conventional painkillers (e.g. paracetamol, co-codamol)		-- --
Opioids (e.g. Codeine, morphine, oxycodone, tramadol)		-- --
Nuropathic painkillers (amitriptyline, pregabalin, gabapentin)		-- --
Anti-inflammatory drugs (e.g. Ibuprofen, naproxen, diclofenac)		-- --
Other, please specify all:		-- --

4. In the last 1 months, please tell us if you have bought any medicine(s), supplements, equipment or devices over the counter, without a prescription, for your rib problem?

	Type of medicine, supplement, equipment or device	Number of times bought	Cost
A)		-- --	£
B)		-- --	£
C)		-- --	£
D)		-- --	£
E)		-- --	£

5. Please state in the last 1 months, if you have had any medical investigations (e.g. X-Ray or blood test) either in an outpatient NHS service or outpatient private care facility for your rib problem?

	Number of times in the NHS	Number of times privately	Cost of private treatment
X-ray	-- --	-- --	£
CT scan	-- --	-- --	£
Ultrasound	-- --	-- --	
MRI	-- --	-- --	£
Chest drain	-- --	-- --	£
Blood test	-- --	-- --	£
Other, please specify all:	-- --	-- --	£

6. In the last 1 months, have you stayed overnight as an inpatient in either an NHS service or private care facility (or both) for your rib problem?

	Number of days as an NHS	Number of days as a private patient	Cost of private treatment
A&E	__ __	__ __	£
Level 0 (General ward)	__ __	__ __	£
Level 1 (Acute)	__ __	__ __	
Level 2 (HDU)	__ __	__ __	£
Level 3 (ICU)	__ __	__ __	£
Other, please specify all:	__ __	__ __	£

Please continue to next section

Section 5 - EQ-5D-5L (INTERVIEWER ADMINISTERED)

First, I would like to ask you about MOBILITY. Would you say that:

1. You have no problems in walking about?
 2. You have slight problems in walking about?
 3. You have moderate problems in walking about?
 4. You have severe problems in walking about?
 5. You are unable to walk about?
-

Next, I would like to ask you about SELF-CARE. Would you say that:

1. You have no problems washing or dressing yourself?
 2. You have slight problems washing or dressing yourself?
 3. You have moderate problems washing or dressing yourself?
 4. You have severe problems washing or dressing yourself?
 5. You are unable to wash or dress yourself?
-

Next, I would like to ask you about USUAL ACTIVITIES, for example work, study, housework, family or leisure activities. Would you say that:

1. You have no problems doing your usual activities?
 2. You have slight problems doing your usual activities?
 3. You have moderate problems doing your usual activities?
 4. You have severe problems doing your usual activities?
 5. You are unable to do your usual activities?
-

Next, I would like to ask you about PAIN OR DISCOMFORT. Would you say that:

1. You have no pain or discomfort?
 2. You have slight pain or discomfort?
 3. You have moderate pain or discomfort?
 4. You have severe pain or discomfort?
 5. You have extreme pain or discomfort?
-

Finally, I would like to ask you about ANXIETY OR DEPRESSION. Would you say that:

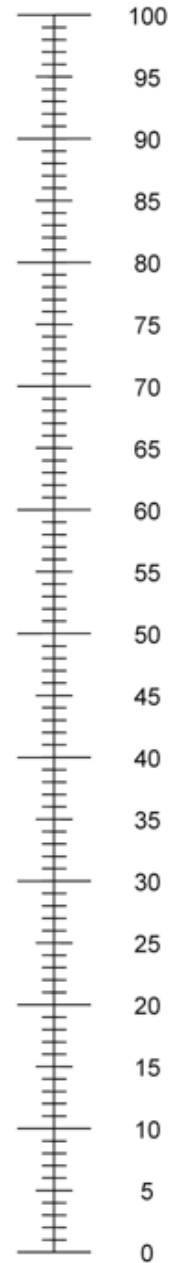
1. You are not anxious or depressed?
 2. You are slightly anxious or depressed?
 3. You are moderately anxious or depressed?
 4. You are severely anxious or depressed?
 5. You are extremely anxious or depressed?
-

EQ-5D VAS

- Now, I would like to ask you to say how good or bad your health is TODAY.
- I would like you to picture in your mind a vertical line that is numbered from 0 to 100.
(Note to interviewer: if interviewing face-to-face, please show the respondent the VAS line.)
- 100 at the top of the line means the best health you can imagine.
0 at the bottom of the line means the worst health you can imagine.
- I would now like you to tell me the point on this line where you would put your health TODAY.
(Note to interviewer: mark the line at the point indicating the respondent's health today. Now, please write the number you marked on the line in the box below.)

THE RESPONDENT'S HEALTH TODAY =

The best health you can imagine



The worst health you can imagine

Section 6 - Short-Form McGill Pain Questionnaire-2 (SF-MPQ-2)

SF-MPQ-2 © R. Melzack and the Initiative on Methods, Measurement, and Pain Assessment in Clinical Trials (IMMPACT), 2009. All Rights Reserved.

This questionnaire provides you with a list of words that describe some of the different qualities of pain and related symptoms. Please select the numbers that best describe the intensity of each of the pain and related symptoms you felt during the past 7 days. Use 0 if the word does not describe your pain or related symptoms.

1. Throbbing pain	none	0	1	2	3	4	5	6	7	8	9	10	worst possible
2. Shooting pain	none	0	1	2	3	4	5	6	7	8	9	10	worst possible
3. Stabbing pain	none	0	1	2	3	4	5	6	7	8	9	10	worst possible
4. Sharp pain	none	0	1	2	3	4	5	6	7	8	9	10	worst possible
5. Cramping pain	none	0	1	2	3	4	5	6	7	8	9	10	worst possible
6. Gnawing pain	none	0	1	2	3	4	5	6	7	8	9	10	worst possible
7. Hot-burning pain	none	0	1	2	3	4	5	6	7	8	9	10	worst possible
8. Aching pain	none	0	1	2	3	4	5	6	7	8	9	10	worst possible
9. Heavy pain	none	0	1	2	3	4	5	6	7	8	9	10	worst possible
10. Tender	none	0	1	2	3	4	5	6	7	8	9	10	worst possible
11. Splitting pain	none	0	1	2	3	4	5	6	7	8	9	10	worst possible
12. Tiring-exhausting	none	0	1	2	3	4	5	6	7	8	9	10	worst possible
13. Sickening	none	0	1	2	3	4	5	6	7	8	9	10	worst possible
14. Fearful	none	0	1	2	3	4	5	6	7	8	9	10	worst possible
15. Punishing-cruel	none	0	1	2	3	4	5	6	7	8	9	10	worst possible
16. Electric-shock pain	none	0	1	2	3	4	5	6	7	8	9	10	worst possible
17. Cold-freezing pain	none	0	1	2	3	4	5	6	7	8	9	10	worst possible
18. Piercing	none	0	1	2	3	4	5	6	7	8	9	10	worst possible

19. pain caused by light touch

none

0	1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	---	----

worst possible

20. Itching

none

0	1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	---	----

worst possible

21. Tingling or 'pins and needles'

none

0	1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	---	----

worst possible

22. Numbness

none

0	1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	---	----

worst possible

For any information on the use of the SF-MPQ-2, please contact Mapi Research Trust, Lyon, France. Internet: <https://eprovide.mapi-trust.org>

Please continue to next section

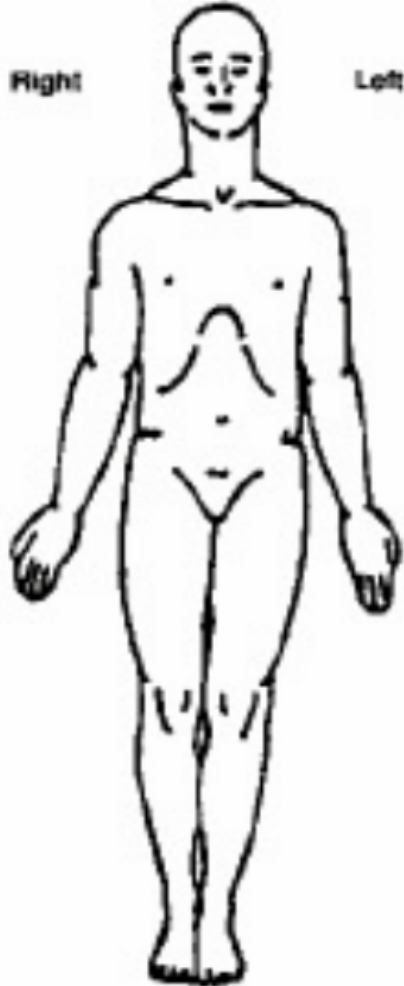
Section 7 - BRIEF PAIN INDEX (short form)

1. Throughout our lives, most of us have had pain from time to time (such as minor headaches, sprains, and toothaches). Have you had pain other than these everyday kinds of pain today?

Yes No

2. On the diagram, shade in the areas where you feel pain. Put an X on the area that hurts the most.

Front



Back



3) Please rate your pain by circling the one number that best describes your pain at its **WORST** in the past 24 hours

0 1 2 3 4 5 6 7 8 9 10
 No Pain Pain As Bad As You Can Imagine

4. Please rate your pain by marking the box beside the number that best describes your pain at its **LEAST** in the last 24 hours.

0 1 2 3 4 5 6 7 8 9 10
 No Pain Pain As Bad As You Can Imagine

5. Please rate your pain by marking the box beside the number that best describes your pain on the **AVERAGE**

0 1 2 3 4 5 6 7 8 9 10
 No Pain Pain As Bad As You Can Imagine

6. Please rate your pain by marking the box beside the number that tells how much pain you have **RIGHT NOW**.

0 1 2 3 4 5 6 7 8 9 10
 No Pain Pain As Bad As You Can Imagine

7. What treatments or medications are you receiving for your pain?

8. In the last 24 hours, how much relief have pain treatments or medications provided? Please mark the box below the percentage that most shows how much relief you have received.

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%
 Complete Relief
 No Relief Complete Relief

9. Mark the box beside the number that describes how, during the past 24 hours, pain has interfered with your:

A. General Activity	<input type="checkbox"/> 0 Does Not Interfere	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8	<input type="checkbox"/> 9	<input type="checkbox"/> 10 Completely Interferes
B. Mood	<input type="checkbox"/> 0 Does Not Interfere	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8	<input type="checkbox"/> 9	<input type="checkbox"/> 10 Completely Interferes
C. Walking Ability	<input type="checkbox"/> 0 Does Not Interfere	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8	<input type="checkbox"/> 9	<input type="checkbox"/> 10 Completely Interferes
D. Normal Work (includes both work outside the home and housework)	<input type="checkbox"/> 0 Does Not Interfere	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8	<input type="checkbox"/> 9	<input type="checkbox"/> 10 Completely Interferes
E. Relations with other people	<input type="checkbox"/> 0 Does Not Interfere	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8	<input type="checkbox"/> 9	<input type="checkbox"/> 10 Completely Interferes
F. Sleep	<input type="checkbox"/> 0 Does Not Interfere	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8	<input type="checkbox"/> 9	<input type="checkbox"/> 10 Completely Interferes
G. Enjoyment of life	<input type="checkbox"/> 0 Does Not Interfere	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8	<input type="checkbox"/> 9	<input type="checkbox"/> 10 Completely Interferes

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Section 8 - FORM COMPLETED BY

This form should be completed by the Principal Investigator or researcher who has been delegated the duty of data collection on the Site Signature and Delegation Log.

Form completed by: <i>print name</i>	Signature:	Date of signature: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
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