**Date of Completion: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient Initials: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Participant Trial Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Time-point:**  Chemotherapy cycle 4 visit 

3 weeks post chemotherapy visit 

4 month after chemotherapy 

6 month after chemotherapy 

**Completion Instructions**

When you entered the trial you kindly agreed to complete this questionnaire. This is an important part of the trial and we would very much appreciate your efforts in completing and returning it. The research nurse can assist you if required. [The questionnaire is uploaded directly onto the study database.]

The following pages contain questions that relate to you, your general health and how any treatments are affecting you. Please complete them to record the amount of care you have received and expenses you have incurred, including help and support from your family, friends and social welfare benefits. This can include those due to any health problems, not just your cancer and its treatment.

If possible please fill in this questionnaire prior to the chemotherapy whilst in treatment or prior to providing the blood sample at your post-chemotherapy clinic visits. If this is not possible we would still like you to complete the questionnaire at your earliest possible convenience.

Once you have completed the questionnaire please just hand it to the research nurse /[post to XXX]/ [in the following times just press complete and the questionnaire is sent automatically to the ECTU].

If you have any questions about this questionnaire please contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Thank you very much for your time and effort.**

**Health questions** EUROQOL© EQ-5D-5L (2015)

**[Insert EQ-5D here]**

**Employment and support**

When you are answering these questions **for the first time please refer to the last three month**. After that please **refer to the time between** the last questionnaire and the actual one.

|  |  |
| --- | --- |
| Were you in employment before you started treatment? | Yes  No  |
| * If yes, how much time have you taken off work due to your health
 | \_\_\_\_\_\_days |
| * If yes, how much earnings have you lost due to your health and its treatment?
 | £ \_\_\_\_\_\_\_\_\_\_ |
|  |  |
| Have you received help or support from family or friends? | Yes  No  |
| * If yes, how much time on average have they spent helping you?
 | \_\_\_hours per week |
| If answered yes to receiving support from family or friends: |  |
| * Did they take any time off work to help or support you?
 | Yes  No  |
| * If yes, how much time in total did they take off?
 | \_\_\_\_\_\_days |
|  |  |
| Do you receive any state benefits (excluding pension) or other financial support? | Yes  No  |
| If yes please specify:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Healthcare**

Please record the **number** of services you have used **since the last questionnaire** including those due to any health problems, not just those referring to cancer and its treatment when filling in this questionnaire.

**Hospital**

This refers to any contacts you make with the hospital. This includes overnight stays in hospital, outpatient visits, telephone calls to hospital-based health professionals and physiotherapy for example.

|  |  |  |
| --- | --- | --- |
| **Type of service** | Have you used the service in the past 3 months?*(tick if yes)* | Total number of days |
| Hospital inpatient stay (>24 hours, or with an overnight stay) |  | \_\_\_\_\_\_\_ |
| Unscheduled hospital assessment (<24hrs without an overnight stay) |  | < 1 |

Please specify all outpatient services that you have used **since the last questionnaire**.

|  |  |  |  |
| --- | --- | --- | --- |
| **Type of Outpatient service** | Have you used the service in the past 3 months? *(tick if yes)* | Total number of visits | Total number of contacts by telephone |
| Hospital doctor |  |  |  |
| Surgeon |  |  |  |
| Hospital nurse |  |  |  |
| Breast cancer nurse |  |  |  |
| Physiotherapist |  |  |  |
| Cancer treatment helpline |  |  |  |
| NHS direct |  |  |  |
| Other: |  |  |  |
|  |  |  |  |

Please specify any tests or scans performed in the hospital (e.g. x-ray, CT-scan) **since the last questionnaire**.

|  |  |
| --- | --- |
| **Description** | **Number** |
| Mammogram |  |
| X-ray |  |
| CT-Scan |  |
| Ultrasound |  |
| MRI Scan |  |
| Bone Scan |  |
| ECG |  |
| Other: |  |

**Community**

This refers to all health care and social care that is **not** based in the hospital. This includes your GP, practice or community nurse, social worker, home help, physiotherapist etc.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Type of service** | **Have you used the service in the past 3 months?** *(tick if yes)* | **Total number of clinic visits** | **Total number of home visits** | **Total number of contacts by telephone** |
| GP, surgery |  |  |  |  |
| Nurse |  |  |  |  |
| Psychiatrist or Psychologist or Psychotherapist |  |  |  |  |
|  |
|  |
| Physiotherapist |  |  |  |  |
| Other: |  |  |  |  |

**Charity** *(e.g. MacMillan, Maggie’s, Breast Cancer Care,… others please specify)*

|  |  |  |
| --- | --- | --- |
| **Type/name of Charity** | **Reason/Treatment** | **Number of visits** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

**Travel**

|  |  |
| --- | --- |
| How many miles have you travelled by car?  | \_\_\_\_\_\_\_\_\_\_\_ miles |
| How much have you spent on health-care related parking? | £ \_\_\_\_\_\_\_\_\_\_\_\_\_ |
| How much have you spent on fares for public transport, taxis, etc.? | £ \_\_\_\_\_\_\_\_\_\_\_\_\_ |

This section refers to how much you spent on travel to attend hospital or other health and social care appointments, including any unplanned visits. When you are answering these questions **please refer to the time since the last questionnaire.**

**Other expenses**

Do you pay for your prescriptions? Yes  No 

Have you personally incurred any other expenses due to your health or treatment?

(e.g. home adaptations, extra laundry, cleaning services)

Please fill in **all costs of the last three month or since the last questionnaire**.

|  |  |
| --- | --- |
| **Description** | **Total cost (£)** |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |

End of questionnaire ***Thank you for your time and effort***