CYCLE

McMaster University Health Sciences

CYCLE RCT 90-Day Follow-Up – Patient Log

Please keep track of the following information **as applicable** from your hospital discharge date: (*insert hospital discharge date: dd/mm/yyyy*) until: (*insert randomization date +90d: dd/mm/yyyy)*

Living Facilities

Number of days spent in long term care facility since hospital discharge: __________

Number of days spent in retirement home since hospital discharge: __________

Emergency Room Visits

(If more than three visits please record information on a separate piece of paper)

Visit #1: Reason for Visit: ______________________________

Visit #2: Reason for Visit: ______________________________

Visit #3: Reason for Visit: ______________________________

Admissions to Hospital

(If more than three readmissions please record information on a separate piece of paper)

Admission #1:

Reason for Admission: ______________________________

Major Surgery/Procedure (if any): ______________________________

Discharge Location: ______________________________

Admission Date: mm dd yyyy Discharge Date: mm dd yyyy

Number of days in ICU/CCU: __________

Admission #2:

Reason for Admission: ______________________________

Major Surgery/Procedure (if any): ______________________________

Discharge Location: ______________________________

Admission Date: mm dd yyyy Discharge Date: mm dd yyyy

Number of days in ICU/CCU: __________

Admission #3:

Reason for Admission: ______________________________

Major Surgery/Procedure (if any): ______________________________

Discharge Location: ______________________________

Admission Date: mm dd yyyy Discharge Date: mm dd yyyy

Number of days in ICU/CCU: __________

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Family Doctor Visits

Number of visits since hospital discharge: _________

How many of these visits do you feel were because of your initial ICU admission? _________

Specialist Visits

Please indicate if you have visited any of the following specialists since your hospital discharge. If so, please keep track of the number of visits, how many you feel were related to your initial ICU admission, and whether or not you were reimbursed by the government and/or an insurance plan for these visits.

Specialist	Tick if yes	Number of Visits	Number related to initial ICU admission	Reimbursed by government and/or insurance plan? Tick if yes
Neurologist	☐	_________	_________	☐
Respirologist	☐	_________	_________	☐
Cardiologist	☐	_________	_________	☐
Dermatologist	☐	_________	_________	☐
Ear/Nose/Throat Specialist	☐	_________	_________	☐
Gastroenterologist	☐	_________	_________	☐
Physiatrist (Rehabilitation Doctor)	☐	_________	_________	☐
Nephrologist	☐	_________	_________	☐
Psychiatrist	☐	_________	_________	☐
Surgeon	☐	_________	_________	☐
Dentist	☐	_________	_________	☐
Other: ____________________________	☐	_________	_________	☐
Other: ____________________________	☐	_________	_________	☐

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Other Healthcare Professionals/Services

Please indicate if you have seen any other healthcare professionals or used any of the following services since your hospital discharge. If so, please keep track of the number of visits, how many you feel were related to your initial ICU admission, and whether or not you were reimbursed by the government and/or an insurance plan for these visits.

Professional	Tick if yes	Number of visits	Number related to initial ICU admission	Reimbursed by government and/or insurance plan? Tick if yes
Nurse Practitioner	☐	________	________	☐
Visiting Nurse (e.g. Home Care)	☐	________	________	☐
Private Nurse	☐	________	________	☐
Homemaker/Personal Support Worker	☐	________	________	☐
Physiotherapist	☐	________	________	☐
Occupational Therapist	☐	________	________	☐
Speech Language Pathologist	☐	________	________	☐
Respiratory Therapist	☐	________	________	☐
Dietitian	☐	________	________	☐
Social Worker	☐	________	________	☐
Psychologist	☐	________	________	☐
Chiropractor	☐	________	________	☐
Naturopath/Homeopath	☐	________	________	☐
Employment Retraining Services	☐	________	________	☐
Meals-on-wheels	☐	________	________	☐
Transportation Services (e.g. DARTS)	☐	________	________	☐
Other: ____________________________	☐	________	________	☐
Other: ____________________________	☐	________	________	☐

Return to Work

If you have returned to work since your hospital discharge please record the date of your first day back.

mm	dd	yyyy

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Assistance from Others

If you have required assistance from others to help you with your daily activities since your hospital discharge, please keep track of the following:

Number of weeks you required assistance: _________

Number of hours on average in a typical week you required this assistance: _________

If the person assisting you had to take time off work to do so, approximately how many days did he/she take off?

Number of days: _________