CYCLE RCT #142 **Plate #001** **Visit #000**

Patient ID (site #) (patient type) (patient #) — *1=randomized, 2=eligible non-randomized*

Coded Patient Initials F L

Screening Date (dd/mm/yyyy) 20

SCREENING (Form 1)

1. Inclusion Criteria (please tick the appropriate check-box)

	YES	NO
1. Patient is ≥ 18 years of age	Y ☐	N ☐
2. Patient is invasively mechanically ventilated ≤ 4 days	Y ☐	N ☐
3. Expected additional 2 day ICU stay	Y ☐	N ☐
4. Ability to ambulate independently (with or without gait aid) pre-hospital	Y ☐	N ☐
5. ICU length of stay ≤ 7 days	Y ☐	N ☐

2. Exclusion Criteria

1. Pre-hospital inability to follow simple commands in local language at baseline	Y ☐	N ☐
2. Acute conditions impairing ability to receive cycling (e.g., leg fracture)	Y ☐	N ☐
3. Acute, proven, or suspected central or peripheral neuromuscular weakness (e.g., stroke, Guillian Barre)	Y ☐	N ☐
4. Temporary pacemaker (internal or external)	Y ☐	N ☐
5. Expected hospital mortality ≥ 90%	Y ☐	N ☐
6. Equipment unable to fit patient's body dimensions (i.e., amputation, morbid obesity)	Y ☐	N ☐
7. Palliative goals of care	Y ☐	N ☐
8. Pregnancy	Y ☐	N ☐
9. Specific surgical exclusion as stipulated by surgery team or ICU team (specify) _____	Y(specify) ☐	N ☐
10. Physician declines (i.e., severely impaired skin integrity, unstable in other ways) (specify) _____	Y(specify) ☐	N ☐
11. Patient already able to march on the spot at time of screening	Y ☐	N ☐
12. Cycling Exemption not resolved during 1st 4 days of MV	Y(check all; specify if necessary) ☐	N ☐

- ☐ 1. Increase in inotropes/vasopressors (2h)
- ☐ 2. Active MI, or unstable/uncontrolled arrhythmia per ICU team
- ☐ 3. MAP <60 or >110 (2h) or out of range for this patient per ICU team
- ☐ 4. HR <40 or >140 (2h)
- ☐ 5. SpO_2 <88% (2h) or out of range for this patient per ICU team
- ☐ 6. Neuromuscular blocker (4h)
- ☐ 7. Severe agitation RASS >2 or SAS >6 or equivalent (2h)
- ☐ 8. Uncontrolled pain
- ☐ 9. Changes in goals to palliative care
- ☐ 10. Other concern (e.g., active haemorrhage, acute peritonitis, new pelvic, groin, or extremity wound precluding cycling, new known or suspected muscle inflammation) (specify) _____

3. Study Eligible Non-Randomized Patients (enter into iDataFax)

1. Patient or SDM/ LAR declines consent	Y ☐	N ☐
2. Patient unable to give consent and no SDM/ LAR identified	Y ☐	N ☐
3. Physician declines patient or SDM/ LAR to be approached (specify) _____	Y ☐	N ☐
4. Consent not obtained due to other reason (check ONE box only, for items a through f)	Y ☐	N ☐

FULL PT STAFF
- ☐ a. Insufficient PT resources and no CYCLE patients enrolled in ICU
- ☐ b. Insufficient PT resources because CYCLE patient(s) enrolled in ICU
- ☐ c. No PT available (off site, no PT around)

PT STAFF
- ☐ d. Insufficient PT resources (e.g. randomization on hold → *only use after consulting with Methods Centre)*
- ☐ e. No RC available (off site, not available to screen)
- ☐ f. Other reason (specify) _____

5. Previously enrolled in this study (previous admit). **Prior ID:** _____ Y ☐ N ☐

4. Patient Status (check ONE box only) **Eligible, non-randomized** ☐ **Included** (go to **Randomization Form 2)** ☐

5. Who provided consent? (check ONE box only) Patient ☐ SDM/ LAR ☐

6. Who obtained consent? (check ONE box only) RC ☐ Site Investigator ☐ ICU MD ☐

CYCLE RCT #142 **Plate #005** **Visit #000**

Patient ID [ ][ ] 1 [ ][ ][ ] (site #) (patient #)

Coded Patient Initials [ ][ ] F L

RANDOMIZATION (Form 2)

FOR RESEARCH COORDINATOR

1. Age of patient

☐ **≥ 65 years**

☐ **≤ 64 years**

2. Date of birth [ ][ ] [ ][ ] [ ][ ][ ][ ] (dd/mm/yyyy)

via web: www.randomize.net

Randomization Instructions

a) Go to www.randomize.net

b) Select "Account Login"

c) Enter "Login ID" and "Password" (see Research Coordinator Binder); **do not change password;** if forgotten, contact Methods Centre

d) Select "ENROLL A PATIENT"

e) Select trial name "CYCLE RCT"

f) Enter three-digit patient number to complete five-digit patient ID

(Note: three-digit patient number is randomization/enrolment #)

3. Study assignment (check one)

☐ **CYCLING + ROUTINE PT/ REHAB**

☐ **ROUTINE PT/ REHAB**

4. Date and local time of randomization [ ][ ] [ ][ ] 2 0 [ ][ ] (dd/mm/yyyy) **Time** [ ][ ] : [ ][ ] (24h - hr:min)

5. Date of consent [ ][ ] [ ][ ] 2 0 [ ][ ] (dd/mm/yyyy)

6. Initials of person who conducted the randomization [ ][ ] F L

CYCLE RCT #142 **Plate #010** **Visit #000**

Patient ID [ ][ ] 1 [ ][ ][ ] (site #) (patient #) Coded Patient Initials [ ][ ] F L

BASELINE (Form 3A.1 of 2)

TO BE COMPLETED AT THE TIME OF CONSENT WITH SDM/ LAR and/ or PATIENT

Instructions: Ask the patient or their SDM/ LAR the following regarding the patient's pre-hospital status

1. Pre-Hospitalization Employment Status (check ONE box that bests describes the patient's pre-hospital employment status)

- ☐ Part-time work
- ☐ Full-time work
- ☐ Retired
- ☐ Disability
- ☐ Unknown
- ☐ Other (specify)_____

2. Pre-Hospitalization Living Status [before coming to the hospital, where was the patient living? (check ONE box)]

- ☐ Home (independent)
- ☐ Home (with home care)
- ☐ Home (with unpaid caregiver assistance)
- ☐ Retirement Home (independent)
- ☐ Assisted Living Facility (mostly independent)
- ☐ Nursing Home/Long Term Care Facility
- ☐ Chronic Care Facility/Complex Continuing Care Skilled Nursing Facility
- ☐ Long Term Acute Care (LTAC)
- ☐ Inpatient Rehabilitation
- ☐ Acute Care Hospital
- ☐ Other (specify) _____

3. Pre-Hospitalization Marital Status (check ONE box)

☐ Single ☐ Married or Common law ☐ Separated or Divorced ☐ Other (specify) _____

4. Pre-Hospitalization Activities of Daily Living (ADL) (check ONE box per activity)

ACTIVITY	INDEPENDENT	DEPENDENT
BATHING (e.g. sponge, shower, or tub)	☐ Assistance only in bathing a single part (as back or disabled extremity) or bathes self completely	☐ Assistance in bathing more than one part of body, or assistance in getting in or out of tub, or does not bathe self
DRESSING	☐ Gets clothes from closets and drawers, and puts on clothes, outer garments and braces, and manages fasteners (act of tying shoes excluded)	☐ Does not dress self, or remains partially undressed
GOING to the TOILET	☐ Gets to toilet, gets on-and-off toilet, arranges clothes, and cleans organs of excretion (may manage own bedpan used at night and may not be using mechanical supports)	☐ Uses bedpan or commode, or receives assistance in getting to and using toilet
TRANSFER	☐ Moves in and out of bed independently, and moves in and out of chair independently (may or may not use mechanical supports)	☐ Assistance in moving in-and-out of bed and/or chair; does not perform one or more transfers
CONTINENCE	☐ Urination and defecation entirely self-controlled	☐ Partial or total incontinence in urination or defecation, or partial or total control by enemas, catheters, or regulated use of urinals &/or bedpans
FEEDING	☐ Gets food from plate or its equivalent into mouth. Note: Precutting of meat and preparation of food, as buttering bread are excluded	☐ Assistance in the act of feeding, or does not eat at all or parenteral (e.g. intravenous TPN) feeding

5. Pre-Hospitalization Functional Status Score for ICU (please score each activity below from 0 - 7)

- ☐ Rolling
- ☐ Lie to sit
- ☐ Sit @ edge of bed
- ☐ Sit to stand
- ☐ Bed to chair
- ☐ *Walking

Scoring

0 = Not able to perform
1 = Total assistance (subject 0% +)
2 = Maximal assistance (subject 25% +)
3 = Moderate assistance (subject 50% +)
4 = Minimal assistance (subject 75% +)
5 = Supervision
6 = Modified independence (device)
7 = Complete independence (timely and safely)

***Considerations for walking**

**6 = Modified independence for walking [with device (e.g., cane walker, adapted shoe) ≥ 150 feet (~1/2 football field)]*

**7 = Complete independence for walking (no device) ≥ 150 feet (~1/2 football field) in safe and timely manner)*

CYCLE RCT #142 Plate #011 Visit #000

Patient ID (site #) 1 (patient #) Coded Patient Initials F L

BASELINE (Form 3A.2 of 2)

TO BE COMPLETED AT THE TIME OF CONSENT WITH SDM/ LAR and/ or PATIENT

6. Pre-Hospitalization Admission Frailty Scale

Please record the participant's baseline health status from 2 weeks before ICU admission
Considering the patient's pre-hospital admission status, please select the highest score from the descriptions below from 1 to 9.
If the patient has characteristics from higher descriptors, then please report the highest score.

SCORE ☐

1. **VERY FIT**: People who are robust, active, energetic and motivated. These people commonly exercise regularly. They are among the fittest for their age.

2. **WELL**: People who have **no active disease symptoms** but are less fit than category 1. Often, they exercise or are very **active occasionally**,e.g. seasonally

3. **MANAGING WELL**: People whose **medical problems are well controlled,** but are **not regularly active** beyond routine walking.

4. **VULNERABLE**: While **not dependent** on others for daily help, often **symptoms limit activities.** A common complaint is being "slowed up",and/or being tired during the day.

5. **MILDLY FRAIL**: These people often have **more evident slowing**, and need help in **high order IADLS** (finances, transportation, heavy housework, medications). Typically, mild frailty progressively impairs shopping and walking outside alone, meal preparation and housework.

6. **MODERATELY FRAIL**: People who need help with **all outside activities** and with **keeping house**. Inside, they often have problems with stairs and need **help with bathing** and might need minimal assistance (cuing, standby) with dressing.

7. **SEVERELY FRAIL**: **Completely dependent for personal care**, from whatever cause (physical or cognitive). Even so, they seem stable and not at high risk of dying (within ~ 6 months).

8. **VERY SEVERELY FRAIL**: Completely dependent, approaching the end of life. Typically, they could not recover even from a minor illness

9. **TERMINALLY ILL**: Approaching the end of life. This category applies to people with **a life expectancy <6 months**, who are **not otherwise evidently frail.**

Scoring frailty in people with dementia: The degree of frailty corresponds to the degree of dementia.

Common **symptoms in mild dementia** include forgetting the details of a recent event, though still remembering the event itself, repeating the same question/story and social withdrawal.

In **moderate dementia**, recent memory is very impaired, even though they seemingly can remember their past life events well. They can do personal care with prompting.

In **severe dementia**, they cannot do personal care without help.

CYCLE RCT #142 **Plate #012** **Visit #000**

Patient ID (site #) 1 (patient #) Coded Patient Initials F L

BASELINE (Form 3B.1 of 2)

1. **Study hospital admit date** 2 0
2. **Study ICU admit date and time** 2 0 **Time** :
3. **Intubation date and time** (most recent intubation prior to enrollment) 2 0 **Time** : (24h - hr:min)
4. **Routine PT/rehab inital session assessment in ICU date** 2 0 (dd/mm/yyyy)
5. **Sex** ☐ Female ☐ Male
6. **Height** ☐ cm ☐ inches
7. **Actual weight (ICU admission)** ☐ kg ☐ lbs

Instructions: *Calculate BMI; if > 30 kg/m^2, please check box "38F18" in "Co-morbid Disease" section on Baseline Form 3B.2*

$$BMI_{(metric)} = \frac{weight_{kg}}{height^2_m} \quad BMI_{(imperial)} = \frac{weight_{lbs}}{height^2_{inches}} \times 703$$

Note: 1 kg = 2.2 lbs; 1 metre = 39.37 inches

8. **Race/Ethnicity** ☐ White ☐ Hispanic or Latino ☐ Black or African ☐ American Indian (North or South) ☐ Asian (incl. Far East, SE Asia or Indian subcontinent) ☐ Other (specify) _____

9. **Daily (24 hour) estimated total goal nutritional requirements** (review dietician and/or nutritionist consults)
**Note: if reported as a RANGE of values, please use the LOWEST value of the given range*

   1. **Energy** (kcal, kJ or other) ☐ No data ☐ **(#)** ☐ kcal ☐ kJ ☐ Other (specify) _____
   2. **Protein** (grams or other) ☐ No data ☐ **(#)** ☐ grams ☐ Other (specify) _____

10. **APACHE II score** (first 24 hours in study ICU) ☐ **(#)**
11. **APACHE III admission diagnosis code** ☐ **(#)** (If admitted from OR or PARR code should be 48-85; If "other" diagnosis code selected, specify) _____
12. **Chronic Health Index from APACHE,** (check ALL that apply)
    - ☐ 1. Hepatic failure
    - ☐ 2. Cirrhosis
    - ☐ 3. Heart failure
    - ☐ 4. Respiratory failure
    - ☐ 5. Chronic dialysis (ESRD)
    - ☐ 6. Lymphoma
    - ☐ 7. Metastatic cancer *(within 5 years)*
    - ☐ 8. Leukemia
    - ☐ 9. Multiple myeloma
    - ☐ 10. AIDS
    - ☐ 11. Other immunocompromise *(chemotherapy, radiotherapy, alcoholism, recent high dose steroids ≥ 15 mg/kg for ≥ 5 days or steroids over last 30 days)*
      - ☐ Check if HIV
    - ☐ 12. **NONE (check one)**
13. **Location immediately prior to this ICU admission** (check ONE box):
    - ☐ Emergency Department
    - ☐ Hospital Floor/Ward (including step-down units)
    - ☐ Other hospital Emergency, admit date:
    - ☐ Other hospital ICU, admit date:
    - ☐ Other hospital ward, admit date:

      Other hospital/site admit date: 2 0 (dd/mm/yyyy)
    - ☐ Operating Theatre /Recovery room (specify)
      - ☐ Emergency Surgery
      - ☐ Elective Surgery
    - ☐ Other (specify) _____

CYCLE RCT #142 **Plate #013** **Visit #000**

Patient ID [ ][ ] 1 [ ][ ][ ] (site #) (patient #) Coded Patient Initials [ ][ ] F L

BASELINE (Form 3B.2 of 2)

14. Co-morbid Disease - Charlson Comorbidity Index (C) & Functional Co-morbidity Index (F) (check ALL that apply)

*** = Do not select more than one disease from these related consecutive diseases**

Respiratory

- [ ] 1C **Chronic pulmonary disease** (incl asthma, COPD, home O_2)
  - [ ] 2F3 Asthma - *also check 1C "Chronic pulmonary disease"*
  - [ ] 3F4 Emphysema - *also check 1C "Chronic pulmonary disease"*
  - [ ] 4F4 COPD (Chronic Obstructive Pulmonary Disease) - *also check 1C "Chronic pulmonary disease"*
- [ ] 5F4 Prior ARDS/ALI

Gastrointestinal

- [ ] 6F12 **Upper gastrointestinal disease** (incl ulcer, hernia, reflux/GERD)
  - [ ] 7CF12 Peptic ulcer disease **ONLY** - *also check 6F12 "Upper GI disease"*

Neurological

- [ ] 8C Dementia (any, incl Alzheimer's, multi-infarct)
- [ ] 9F9 Stroke/CVA or TIA (*also check 11C "Hemiplegia..." if applicable*)
- [ ] 11C Hemiplegia or paraplegia
- [ ] 10F8 Neurologic *(any,* incl MS, Parkinson's, uncontrolled seizures **excl.** CVA/TIA & Dementia)

Endocrine

- [ ] 12CF11 *Diabetes ***without*** end organ damage
- [ ] 13CF11 *Diabetes ***with*** end organ (eye, nerve, or kidney) damage

Infectious Disease

- [ ] 14C *AIDS (No positive test for HIV/clinical diagnosis)
- [ ] 15C *AIDS (Known positive test for HIV)
- [ ] 16C *HIV (No evidence of AIDS)

Musculoskeletal

- [ ] 17F17 Degenerative disc disease (back dz, spinal stenosis or severe chronic back pain)

Mental Health

- [ ] 18F13 Depression
- [ ] 19F14 Anxiety or panic disorders

Cardiac and Vascular

- [ ] 20CF6 Congestive heart failure (CHF)
- [ ] 21F6 Heart disease (conditions affecting heart muscle, valves, or rhythm)
- [ ] 22CF7 Heart attack or Myocardial Infarction (MI)
- [ ] 23F5 Angina
- [ ] 24CF10 Peripheral vascular (PVD) (claudication, art. bypass, AAA>6cm)

Renal

- [ ] 25C *Kidney disease - *mild* (Creatinine 177 - 265 µmol/L)
- [ ] 26C *Kidney disease - *moderate or severe* (Creatinine > 265 µmol/L , dialysis, transplant)

Hematology/ Oncology

- [ ] 27C *Tumor (Solid, **with** metastatic disease)
- [ ] 28C *Tumor (Solid, **without** metastatic disease) *(within past 5 years)*
- [ ] 29C Leukemia (incl AML, CML, ALL, CLL, polycythemia vera)
- [ ] 30C Lymphoma (incl Hodgkin's & non-Hodgkins, lymphosarcoma, and myeloma)

Hepatic

- [ ] 31C *Liver disease - *mild* (Hep B or C, or cirrhosis w/o portal HTN)
- [ ] 32C *Liver disease - *moderate or severe* (varices, ascites, encephalopathy)

Connective Tissue/ Rheumatologic

- [ ] 33F2 Osteoporosis
- [ ] 34C Connective tissue disease - rheumatoid arthritis **ONLY**, or lupus/SLE, myositis
- [ ] 35F1 Arthritis - rheumatoid or osteoarthritis *(also check above options where applicable)*

Other

- [ ] 36F15 Visual impairment (e.g., cataracts, glaucoma, macular degeneration)
- [ ] 37F16 Hearing impairment (can't hear conversation even with hearing aids, if any)
- [ ] 38F18 Obesity and/or body mass index > 30kg/m^2
  Refer to Form 3B.1 BMI calculations; check box if necessary)
- [ ] 39 **NONE**

CYCLE RCT #142 **Plate #015**

Study Day ☐☐

Patient ID ☐☐ 1 ☐☐☐ (site # / patient #) Coded Patient Initials ☐☐ F L

Date ☐☐ ☐☐ 2 0 ☐☐ (dd/mm/yyyy)

DAILY DATA (Form 4.1 of 4)

Day of the week ☐ M ☐ Tu ☐ W ☐ Th ☐ F ☐ Sa ☐ Su

1. Advanced life support strategies received today (check ALL that apply)

1. Airway Access ☐ No ☐ Yes → ☐ ETT ☐ Tracheostomy
2. Mechanical Ventilation (MV) ☐ No → None/Spontaneous (e.g. t-mask, venti-mask, nasal prongs)
   ☐ Yes → ☐ Invasive MV (e.g.pressure assist control, volume assist control, pressure support)
   ☐ Non-Invasive MV (e.g. BIPAP, CPAP by mask not ETT or trach, e.g., nocturnal)
3. Other Ventilation Strategy ☐ No ☐ Yes → ☐ ECMO/ECLS ☐ Nitric oxide ☐ High-flow nasal cannula (e.g. AIRVO, Optiflow)
   ☐ Other (specify) _____
4. Vasopressor / Inotrope infusions ☐ No ☐ Yes
   (e.g., dopamine, norepinephrine, phenylephrine, epinephrine, milrinone, vasopressin)
5. Dialysis ☐ No ☐ Yes → ☐ Intermittent (IHD) ☐ Continuous (CRRT) ☐ Peritoneal ☐ Sustained low efficiency (SLED)
   ☐ Other (specify) _____

2. Drugs (check ALL that apply)

1. Systemic corticosteroid ☐ No ☐ Yes → ☐ Dexamethasone ☐ Methylprednisolone ☐ Hydrocortisone ☐ Prednisone ☐ Other (specify) _____
   → **TOTAL DAILY DOSE** ☐☐☐☐.☐☐ **(mg)**
2. Opiates ☐ No ☐ Yes → ☐ Infusion ☐ Bolus ☐ Other route (specify) _____
   (e.g., Fentanyl, Remifentanyl, Hydromorphone, Morphine, Oxycodone, Demerol, (Percocet), Codeine (Tylenol #1, 2, or 3), etc.)
3. Benzodiazepines ☐ No ☐ Yes → ☐ Infusion ☐ Bolus ☐ Other route (specify) _____
   (e.g., Midazolam (Versed), Lorazepam (Ativan), Clonazepam, Diazepam, etc.)
4. Propofol ☐ No ☐ Yes → ☐ Infusion ☐ Bolus
5. Neuromuscular blockers ☐ No ☐ Yes → ☐ Infusion ☐ Bolus
   (e.g., Cisatracurium, Rocuronium, Vecuronium, Atracurium, Pancuronium, Succinylcholine, etc.)

3. MODS score (record values closest to 0800)

Platelets (platelets /mL*10*$^{-3}$) ☐ N/A ☐☐☐☐☐

Creatinine (µmol/L) ☐ N/A ☐☐☐☐☐

Bilirubin (µmol/L) ☐ N/A ☐☐☐☐☐

PaO_2/FiO_2 ☐ N/A ☐☐☐ **OR** ☐ N/A **PaO_2** (mmHg) ☐☐☐ / **FiO_2** (0.21-1.00) ☐.☐☐

HR (BPM) ☐ N/A ☐☐☐

MAP (mmHg) ☐ N/A ☐☐☐

CVP (mmHg) ☐ N/A ☐☐

***Glasgow Coma Score** ☐ Not recorded ☐☐ **(3 - 15 OR *3T-11T)**

☐ Receiving sedation/opioids/NMB's when GCS reported?

☐ *GCS verbal component = "T" (T = "1" included in GCS #)

4. RASS and CAM-ICU (RASS and CAM-ICU to be taken at same time and closest to 0800)

1. RASS ☐ Not done ☐ (-) ☐ (+) ☐ **(0 - 5)**

SAS / VAMASS → RASS Conversion Chart

SAS	1	2	X	3	X	4	5	6	7	X
RASS	**-5**	**-4**	**-3**	**-2**	**-1**	**0**	**1**	**2**	**3**	**4**
VAMASS	0	X	1	2	X	3	4	5	6	X

2. CAM-ICU ☐ Not done ☐ Negative ☐ Positive ☐ Unable to Ax (RASS = -4 or -5)

**Scores ≥ 4 on Intensive Care Delirium Screening Checklist / ICDSC = CAM-ICU "Positive"*

CYCLE RCT #142 **Plate #016**

Study Day ☐☐

Patient ID ☐☐ 1 ☐☐☐ (site # / patient #) Coded Patient Initials ☐☐ F L Date ☐☐ ☐☐ 2 0 ☐☐ (dd/mm/yyyy)

DAILY DATA (Form 4.2 of 4)

5. Nutrition

1. Enteral nutrition (EN) received today (check ONE type below; if >1 type received, select type providing the highest volume received)

☐ No ☐ Yes → **24 hour total EN volume delivered** ☐☐☐☐☐ **(ml)**

☐ Ensure High Protein (1.0 kcal/mL)	☐ IsoSOURCE VHN/Fiber (1.0 kcal/mL + fibre)	☐ Nutrison Protein Plus w/ Multifibre	☐ Peptamen Intense
☐ Ensure Plus Calories (1.5 kcal/mL)	☐ IsoSOURCE VHP/1.0 HP (1.0 kcal/mL)	☐ Nutrison Concentrated	☐ Promote (1.0 kcal/mL)
☐ Fibersource HN	☐ Jevity 1.0 Cal (+ fibre)	☐ Novosource GI Forte	☐ Resource 2.0
☐ Glucerna 1.0 kcal/mL + fibre	☐ Jevity 1.2 Cal (+ fibre)	☐ Novosource Renal 2.0	☐ Resource Diabetic
☐ Impact Adv. Rec.	☐ Jevity 1.5 Cal (+ fibre)	☐ Optimental 1.0 kcal/mL	☐ TwoCal HN 2.0 (+ fibre)
☐ IsoSOURCE	☐ Nepro Carb Steady (1.8 kcal/mL + fibre)	☐ Osmolite	☐ Vital 1.0
☐ IsoSOURCE HN 1.2	☐ Novosource Renal 2.0	☐ OXEPA (1.5 kcal/mL)	☐ Vital 1.5
☐ IsoSOURCE HN/Fiber 1.2 (+ fibre)	☐ Nutren 1.5	☐ Peptamen 1.0	☐ Vital Peptide 1.5
☐ IsoSOURCE 1.5	☐ NutriHep (1.5 kcal/mL)	☐ Peptamen 1.5	☐ Vivonex Plus
☐ IsoSOURCE 1.5/Fiber (+ fibre)	☐ Nutrison 8000	☐ Peptamen AF 1.2 Cal (fish-oils and prebiotics)	☐ Vivonex T.E.N.

☐ Other (specify) _____

2. Modular products received today? (check type(s), and record # packages received)

☐ No ☐ Yes →

Beneprotein	☐ Yes → ☐☐ # pkgs	**Prosource**	☐ Yes → ☐☐ # pkgs
Bramino	☐ Yes → ☐☐ # pkgs	**Other (specify)**	☐ Yes → ☐☐ # pkgs
EAS L-Glutamine	☐ Yes → ☐☐ # pkgs		

3. Parenteral nutrition (PN) received today (record total PN volume received and macronutrients (specify units) received during 24 hour period)

☐ No ☐ Yes →

Volume	☐☐☐☐☐ **(ml)**
Dextrose	☐☐☐☐☐.☐☐ **(grams)**
Amino Acid	☐☐☐☐☐.☐☐ **(grams)**
Lipid	☐☐☐☐☐.☐☐ **(grams)**

4. Oral intake received today?

☐ No ☐ Yes →

☐ Oral (food) intake
☐ Oral (fluid) intake
volume not required

5. Patient highest level of activity TODAY (including therapy sessions) [see Form 5, 5R, 5C; patient's chart (e.g. OT/PT/nursing notes)]

SCORE ☐☐ (0-11)

0 - Passively moved by staff (includes passive cycling only)
1 - Any activity in bed, but not moving out of or over edge of bed (includes cycling)
2 - Passively moved to chair (no standing or sitting at edge of bed)
3 - Actively sitting over side of bed with some trunk control (may be assisted)
4 - Standing
5 - Transferring from bed to chair
6 - Marching on the spot (at bedside; ≥ 2steps/foot)
7 - Walking with assistance of 2 or more people (≥5m)
8 - Walking with assistance of 1 person (≥5m)
9 - Walking independently with gait aid (≥5m)
10 - Walking independently without gait aid (≥5m)
11 - Walking up and down stairs

6. Is today a stat. holiday or weekend (i.e. ineligible day to offer and complete CYCLE trial intervention(s))

☐ No ☐ Yes (no CYCLE Trial intervention today)

→ **Did the patient receive any rehab therapy today from PT or OT?** (check one; go to q 13)

☐ No ☐ Yes

CYCLE RCT #142 **Plate #017**

Study Day ☐☐

Patient ID ☐☐ 1 ☐☐☐ (site # / patient #) Coded Patient Initials ☐☐ (F L) Therapist(s) Initials ☐☐☐ ☐☐☐ (F M L F M L) Date ☐☐ ☐☐ 2 0 ☐☐ (dd/mm/yyyy)

DAILY DATA (Form 4.3 of 4)

Day of week ☐ M ☐ Tu ☐ W ☐ Th ☐ F ☐ Sa ☐ Su

7. Was routine PT/ rehab done today?

☐ **Yes (submit Form 5R)**

☐ No *(check one of a, b, c, or d and specify where necessary)*

a) ☐ **Patient discharged from ICU before 1200pm**

b) ☐ **Temporary exemption criteria met** *(check ALL; if #10 specify)*

- ☐ 1. Increase in inotropes/vasopressors (2h)
- ☐ 2. Active MI, or unstable/uncontrolled arrhythmia per ICU team
- ☐ 3. MAP <60 or >110 (2h) or out of range for this patient per ICU team
- ☐ 4. HR <40 or >140 (2h)
- ☐ 5. $Sp0_2$ <88% (2h) or out of range for this patient per ICU team
- ☐ 6. Neuromuscular blocker (4h)
- ☐ 7. Severe agitation RASS >2 or SAS >6 or equivalent (2h)
- ☐ 8. Uncontrolled pain
- ☐ 9. Changes in goals to palliative care
- ☐ 10. Other concern [e.g., active haemorrhage, acute peritonitis, new pelvic, groin, or extremity wound precluding routine PT/ rehab, new known or suspected muscle inflammation **(specify below)**]

_____

c) ☐ **Other reasons routine PT/rehab not received** (check all that apply)

Refusals

☐ Tired ☐ Having a bad day ☐ Family declined ☐ Non-verbal behaviours indicating disinterest ☐ Other reason patient declined (specify) _____

Other activity prioritized by therapist

☐ Cycling ☐ Other (specify) _____ ☐ Patient not scheduled for therapy

Therapist not available

☐ Workload ☐ Other (specify) _____

Patient not available

☐ Out of ICU ☐ While in ICU (procedure, test, etc.) ☐ Other (specify) _____

d) ☐ **Other reason (specify)** _____

8. Was cycling done today?

☐ **N/A, patient not randomized to cycling**

☐ **Yes (submit Form 5C)**

☐ No *(check one of a, b, c, d, or e and specify where necessary)*

a) ☐ **Patient discharged from ICU before 1200pm**

b) ☐ **Patient marched on the spot for 2 consecutive days**

c) ☐ **Temporary exemption criteria met** *(check ALL; if #10 specify)*

- ☐ 1.Increase in inotropes/vasopressors (2h)
- ☐ 2. Active MI, or unstable/uncontrolled arrhythmia per ICU team
- ☐ 3. MAP <60 or >110 (2h) or out of range for this patient per ICU team
- ☐ 4. HR <40 or >140 (2h)
- ☐ 5. $Sp0_2$ <88% (2h) or out of range for this patient per ICU team
- ☐ 6. Neuromuscular blocker (4h)
- ☐ 7. Severe agitation RASS >2 or SAS >6 or equivalent (2h)
- ☐ 8. Uncontrolled pain
- ☐ 9. Changes in goals to palliative care
- ☐ 10. Other concern [e.g., active haemorrhage, acute peritonitis, new pelvic, groin, or extremity wound precluding cycling, new known or suspected muscle inflammation **(specify below)**]

_____

d) ☐ **Other reasons cycling not received** (check all that apply)

Refusals

☐ Tired ☐ Having a bad day ☐ Family declined ☐ Non-verbal behaviours indicating disinterest ☐ Other reason patient declined (specify) _____

Other activity prioritized by therapist

☐ Other (specify) _____

Therapist not available

☐ Workload ☐ Other (specify) _____ ☐ No CYCLE-trained therapist available

Patient not available

☐ Out of ICU ☐ While in ICU (procedure, test, etc.) ☐ Other (specify) _____

e) ☐ **Other reason (specify)** _____

9. Total # of screening attempts for cycling today? ☐ N/A ☐ (#)

10A. Therapy session duration (min) → **10B. Therapy type(s) received** → **10C. Safety Events reported**

☐ No PT/ rehab	Session 1	☐☐☐ (min)	→ ☐ Routine PT/ rehab ☐ Cycling	→	☐ No	☐ Yes ***(complete Form 5S)***
☐ N/A	Session 2	☐☐☐ (min)	→ ☐ Routine PT/ rehab ☐ Cycling	→	☐ No	☐ Yes ***(complete Form 5S)***
☐ N/A	Session 3	☐☐☐ (min)	→ ☐ Routine PT/ rehab ☐ Cycling	→	☐ No	☐ Yes ***(complete Form 5S)***

11. Patient highest level of activity from ALL rehabilitation/therapy sessions (includes Forms 5R, 5C, applicable S&F ax's)

☐ No PT/ rehab

SCORE ☐☐ (0-11)

0 - Passively moved by staff (includes passive cycling only)
1 - Any activity in bed, but not moving out of or over edge of bed (includes cycling)
2 - Passively moved to chair (no standing or sitting at edge of bed)
3 - Actively sitting over side of bed with some trunk control (may be assisted)
4 - Standing
5 - Transferring from bed to chair
6 - Marching on the spot (at bedside; ≥ 2steps/foot)
7 - Walking with assistance of 2 or more people (≥5m)
8 - Walking with assistance of 1 person (≥5m)
9 - Walking independently with gait aid (≥5m)
10 - Walking independently without gait aid (≥5m)
11 - Walking up and down stairs

12. Cognitive screening for ICU Awakening Ax: Strength and Function *(Ask the patient to perform all 5 commands; check ALL successful commands)*

☐ No PT/ rehab

SCORE ☐ /5

Successful Commands

- ☐ Open your eyes
- ☐ Look at me
- ☐ Open your mouth and stick out your tongue
- ☐ Nod your head
- ☐ Raise your eyebrows when I count to 5

→

- ☐ Not done, patient unable to follow commands
- ☐ No, score ≤2/5 ***(continue screening)***
- ☐ Yes, score ≥3/5 + ***not appropriate*** for PT ICU Awakening Ax ***(continue screening)***
- ☐ Yes, score ≥3/5 + ***appropriate*** for PT ICU Awakening Ax ***(initiate assessment)***
- ☐ Not done, PT ICU awakening Ax in progress/ complete

DAILY DATA (Form 4.4 of 4)

13. Was the ICU Awakening: Strength and Function Form initiated today?

- ☐ No
- ☐ Yes ***(submit Form SF1)***

14. Was the IPAT Form initiated today?

- ☐ No
- ☐ Yes ***(submit Form RC1)***

15. Last day of study today?

- ☐ No, patient still within study day 28 protocol
- ☐ No, returned to ICU within 72 hours of ICU discharge
- ☐ Yes, patient discharged from the ICU >72 hours, died, or CYCLE RCT protocol stopped at 28 days (submit Forms: SF1-SF4, RC1-RC4, 6 and 7)
- ☐ Yes, consent withdrawn for further data collection (submit Form 7)
  - → Who withdrew consent? (specify)
    - ☐ Patient ☐ Legal SDM/ LAR ☐ Other family member ☐ Physician ☐ Other (specify) _____
  - → Reason for Withdrawal? (specify) _____

CYCLE RCT #142 Plate #020

Study Day ☐☐

Patient ID ☐☐ 1 ☐☐☐ (site # / patient #)

Coded Patient Initials ☐☐ F L

Date ☐☐ ☐☐ 2 0 ☐☐ (dd/mm/yyyy)

DAILY DATA (Form 4A)

If a patient is **discharged from ICU and readmitted within 72 hours,** complete this form ***in place of DAILY DATA (Form 4)*** for each complete study day outside ICU prior to readmission.

1. Did the patient receive any physiotherapy/ rehabiliation therapy while outside ICU today?

☐ No
☐ Yes

Day of week ☐ M ☐ Tu ☐ W ☐ Th ☐ F ☐ Sa ☐ Su

2. Patient highest level of activity outside of ICU today?

SCORE ☐☐ (0-11)

0 - Passively moved by staff (includes passive cycling only)
1 - Any activity in bed, but not moving out of or over edge of bed (includes cycling)
2 - Passively moved to chair (no standing or sitting at edge of bed)
3 - Actively sitting over side of bed with some trunk control (may be assisted)
4 - Standing
5 - Transferring from bed to chair
6 - Marching on the spot (at bedside; ≥ 2steps/foot)
7 - Walking with assistance of 2 or more people (≥5m)
8 - Walking with assistance of 1 person (≥5m)
9 - Walking independently with gait aid (≥5m)
10 - Walking independently without gait aid (≥5m)
11 - Walking up and down stairs

CYCLE RCT #142 **Plate #021**

Study Day ☐☐

Patient ID ☐☐ 1 ☐☐☐ (site # / patient #) Coded Patient Initials ☐☐ (F L) Therapist(s) Initials ☐☐☐ ☐☐☐ (F M L F M L) Date ☐☐ ☐☐ 2 0 ☐☐ (dd/mm/yyyy)

PT THERAPY: WORKSHEET (Form 5)

Day of week ☐ M ☐ Tu ☐ W ☐ Th ☐ F ☐ Sa ☐ Su

1. Was routine PT/ rehab done today?

☐ **Yes (submit Form 5R)**

☐ No *(check one of a, b, c, or d and specify where necessary)*

a) ☐ **Patient discharged from ICU before 1200pm**

b) ☐ **Temporary exemption criteria met** *(check ALL; if #10 specify)*

- ☐ 1. Increase in inotropes/vasopressors (2h)
- ☐ 2. Active MI, or unstable/uncontrolled arrhythmia per ICU team
- ☐ 3. MAP <60 or >110 (2h) or out of range for this patient per ICU team
- ☐ 4. HR <40 or >140 (2h)
- ☐ 5. $Sp0_2$ <88% (2h) or out of range for this patient per ICU team
- ☐ 6. Neuromuscular blocker (4h)
- ☐ 7. Severe agitation RASS >2 or SAS >6 or equivalent (2h)
- ☐ 8. Uncontrolled pain
- ☐ 9. Changes in goals to palliative care
- ☐ 10. Other concern [e.g., active haemorrhage, acute peritonitis, new pelvic, groin, or extremity wound precluding routine PT/ rehab, new known or suspected muscle inflammation **(specify below)**]

c) ☐ **Other reasons routine PT/ rehab not received** (check all that apply)

Refusals

☐ Tired ☐ Having a bad day ☐ Family declined ☐ Non-verbal behaviours indicating disinterest ☐ Other reason patient declined (specify) _____

Other activity prioritized by therapist

☐ Cycling ☐ Other (specify) _____ ☐ Patient not scheduled for therapy

Therapist not available

☐ Workload ☐ Other (specify) _____

Patient not available

☐ Out of ICU ☐ While in ICU (procedure, test, etc.) ☐ Other (specify) _____

d) ☐ **Other reason (specify)** _____

2. Was cycling done today?

☐ **N/A, patient not randomized to cycling**

☐ **Yes (submit Form 5C)**

☐ No *(check one of a, b, c, d, or e and specify where necessary)*

a) ☐ **Patient discharged from ICU before 1200pm**

b) ☐ **Patient marched on the spot for 2 consecutive days**

c) ☐ **Temporary exemption criteria met** *(check ALL; if #10 specify)*

- ☐ 1.Increase in inotropes/vasopressors (2h)
- ☐ 2. Active MI, or unstable/uncontrolled arrhythmia per ICU team
- ☐ 3. MAP <60 or >110 (2h) or out of range for this patient per ICU team
- ☐ 4. HR <40 or >140 (2h)
- ☐ 5. $Sp0_2$ <88% (2h) or out of range for this patient per ICU team
- ☐ 6. Neuromuscular blocker (4h)
- ☐ 7. Severe agitation RASS >2 or SAS >6 or equivalent (2h)
- ☐ 8. Uncontrolled pain
- ☐ 9. Changes in goals to palliative care
- ☐ 10. Other concern [e.g., active haemorrhage, acute peritonitis, new pelvic, groin, or extremity wound precluding cycling, new known or suspected muscle inflammation **(specify below)**]

d) ☐ **Other reasons cycling not received** (check all that apply)

Refusals

☐ Tired ☐ Having a bad day ☐ Family declined ☐ Non-verbal behaviours indicating disinterest ☐ Other reason patient declined (specify) _____

Other activity prioritized by therapist

☐ Other (specify) _____

Therapist not available

☐ Workload ☐ Other (specify) _____ ☐ No CYCLE-trained therapist available

Patient not available

☐ Out of ICU ☐ While in ICU (procedure, test, etc.) ☐ Other (specify) _____

e) ☐ **Other reason (specify)** _____

3. Total # of screening attempts for cycling today? ☐ N/A ☐ (#)

4A. Therapy session duration (min)		**4B. Therapy type(s) received**		**4C. Safety Events reported**	
☐ No PT/ rehab	Session 1 ☐☐☐ (min)	☐ Routine PT/ rehab	☐ Cycling	☐ No	☐ Yes ***(complete Form 5S)***
☐ N/A	Session 2 ☐☐☐ (min)	☐ Routine PT/ rehab	☐ Cycling	☐ No	☐ Yes ***(complete Form 5S)***
☐ N/A	Session 3 ☐☐☐ (min)	☐ Routine PT/ rehab	☐ Cycling	☐ No	☐ Yes ***(complete Form 5S)***

5. Patient highest level of activity from ALL rehabilitation/therapy sessions (includes Forms 5R, 5C, applicable S&F ax's)

☐ No PT/ rehab

SCORE ☐☐ (0-11)

0 - Passively moved by staff (includes passive cycling only)
1 - Any activity in bed, but not moving out of or over edge of bed (includes cycling)
2 - Passively moved to chair (no standing or sitting at edge of bed)
3 - Actively sitting over side of bed with some trunk control (may be assisted)
4 - Standing
5 - Transferring from bed to chair
6 - Marching on the spot (at bedside; ≥ 2steps/foot)
7 - Walking with assistance of 2 or more people (≥5m)
8 - Walking with assistance of 1 person (≥5m)
9 - Walking independently with gait aid (≥5m)
10 - Walking independently without gait aid (≥5m)
11 - Walking up and down stairs

6. Cognitive screening for ICU Awakening Ax: Strength and Function *(Ask the patient to perform all 5 commands; check ALL successful commands)*

☐ No PT/ rehab

SCORE ☐ /5

Successful Commands

- ☐ Open your eyes
- ☐ Look at me
- ☐ Open your mouth and stick out your tongue
- ☐ Nod your head
- ☐ Raise your eyebrows when I count to 5

→

- ☐ Not done, patient unable to follow commands
- ☐ No, score ≤2/5 ***(continue screening)***
- ☐ Yes, score ≥3/5 + ***not appropriate*** for PT ICU Awakening Ax ***(continue screening)***
- ☐ Yes, score ≥3/5 + ***appropriate*** for PT ICU Awakening Ax ***(initiate assessment)***
- ☐ Not done, PT ICU awakening Ax in progress/ complete

CYCLE RCT #142 **Plate #025**

Study Day ☐☐

Patient ID ☐☐ 1 ☐☐☐ (site # / patient #) Coded Patient Initials ☐☐ (F L) Therapist(s) Initials ☐☐☐ ☐☐☐ (F M L / F M L) Date ☐☐ ☐☐ 20☐☐ (dd/mm/yyyy)

PT THERAPY: ROUTINE PT/ REHAB (Form 5R)

Complete form if patient receives any routine therapy (incl. therapy received while cycling)

Day of week ☐ M ☐ Tu ☐ W ☐ Th ☐ F ☐ Sa ☐ Su

1. Pre-routine therapy assessments

SAS / VAMASS → RASS Conversion Chart

SAS	1	2	X	3	X	4	5	6	7	X
RASS	-5	-4	-3	-2	-1	0	1	2	3	4
VAMASS	0	X	1	2	X	3	4	5	6	X

1. RASS ☐ Not done ☐ (-) ☐ (+) ☐ (0 - 5)

2. CAM-ICU ☐ Not done ☐ Negative ☐ Positive ☐ Unable to Ax (RASS = -4 or -5)

**Scores ≥ 4 on Intensive Care Delirium Screening Checklist / ICDSC = CAM-ICU "Positive"*

2. Vitals: highest O_2 % received [21% (room air) - 100%]

Session 1: ☐☐☐ (%) Session 2: ☐ N/A ☐☐☐ (%) Session 3: ☐ N/A ☐☐☐ (%)

3. ALL advanced life support strategies received DURING ANY ROUTINE PT/REHAB today (check ALL that apply)

1. Airway Access ☐ No ☐ Yes → ☐ ETT ☐ Tracheostomy
2. Mechanical Ventilation (MV) ☐ No → None/Spontaneous (e.g. t-mask, venti-mask, nasal prongs); ☐ Yes → ☐ Invasive MV (e.g.pressure assist control, volume assist control, pressure support); ☐ Non-Invasive MV (e.g. BIPAP, CPAP by mask not ETT or trach, e.g., nocturnal)
3. Other Ventilation Strategy ☐ No ☐ Yes → ☐ ECMO/ECLS ☐ Nitric oxide ☐ High-flow nasal cannula (e.g. AIRVO, Optiflow) ☐ Other (specify)
4. Vasopressor / Inotrope infusions *(e.g., dopamine, norepinephrine, phenylephrine, epinephrine, milrinone, vasopressin)* ☐ No ☐ Yes
5. Dialysis ☐ No ☐ Yes → ☐ Intermittent (IHD) ☐ Continuous (CRRT) ☐ Peritoneal ☐ Sustained low efficiency (SLED) ☐ Other (specify)
6. Femoral Catheter in Situ ☐ No ☐ Yes → ☐ Venous ☐ Arterial ☐ Other (specify)

4. Routine PT (usual care) rehabilitation activities (check ALL received)

1. Target: Independent airway clearance

Complete? (Yes = complete row)	Physical Assistance: Percussion	Vibration	Rib springs	Suctioning	Instructions	Repetition	Feedback	Cues	Encouragement	Equipment (specify)
Respiratory Interventions ☐ No ☐ Yes →	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

2. Target: Increase active ROM of limbs

Complete? (Yes = complete row)	Phys. Assist. (PROM, AAROM)	Instructions	Repetition	Feedback	Cues	Encouragement	Motivation	Equipment (specify)
Arms ☐ No ☐ Yes →	☐	☐	☐	☐	☐	☐	☐	☐
Legs ☐ No ☐ Yes →	☐	☐	☐	☐	☐	☐	☐	☐

3. Target: Increase muscle strength

Complete? (Yes = complete row)	Physical Resistance: Therapist	Bands	Weights	Instructions	Repetition	Feedback	Cues	Encouragement	Motivation	Equipment (specify)
Arms ☐ No ☐ Yes →	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Legs ☐ No ☐ Yes →	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

4. Target: Independent transfers

Complete? (Yes = complete row)	Physical Assistance (People): None	Ax1	Ax2	>Ax2	Instructions	Repetition	Feedback	Cues	Encouragement	Motivation	Equipment (specify)
Rolling ☐ No ☐ Yes →	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Lie to sit ☐ No ☐ Yes →	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Sit at EOB ☐ No ☐ Yes →	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Sit to stand ☐ No ☐ Yes →	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Bed to chair ☐ No ☐ Yes →	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

5. Target: Walking

Complete? (Yes = complete row)	Physical Assistance (People): None	Ax1	Ax2	>Ax2	Instructions	Repetition	Feedback	Cues	Encouragement	Motivation	Equipment (specify)
Marching ☐ No ☐ Yes →	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Walking ☐ No ☐ Yes →	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Stairs ☐ No ☐ Yes →	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

5. Any safety events during routine PT/ rehab?

stop session if any of these events occur: **suspected new unstable/ uncontrolled arrhythmia, concern for MI, cardiac arrest, unplanned extubation, fall to knees

☐ No ☐ Yes ***(complete Safety Events Form 5S)***

Comments _____

CYCLE RCT #142 **Plate #030**

Study Day ☐☐

Patient ID ☐☐ 1 ☐☐☐ (site # / patient #) Coded Patient Initials ☐☐ (F L) Therapist(s) Initials ☐☐☐ ☐☐☐ (F M L F M L) Date ☐☐ ☐☐ 2 0 ☐☐ (dd/mm/yyyy)

PT THERAPY: CYCLING (Form 5C)

RT 300 ID ☐☐☐☐☐☐☐ **RT 300 PIN** ☐☐☐☐

Day of week ☐ M ☐ Tu ☐ W ☐ Th ☐ F ☐ Sa ☐ Su

1. Cycling session start time (equipment prepped and enter room)

☐☐ : ☐☐ (24h-hr:min)

2. Pre-cycling therapy assessments

SAS / VAMASS → RASS Conversion Chart

SAS	1	2	X	3	X	4	5	6	7	X
RASS	-5	-4	-3	-2	-1	0	1	2	3	4
VAMASS	0	X	1	2	X	3	4	5	6	X

1. RASS ☐ Not done ☐ (-) ☐ (+) ☐ (0 - 5)

2. CAM-ICU ☐ Not done ☐ Negative ☐ Positive ☐ Unable to Ax (RASS = -4 or -5)

**Scores ≥ 4 on Intensive Care Delirium Screening Checklist / ICDSC = CAM-ICU "Positive"*

3. Vitals: Highest O_2 % received ☐☐☐ (%)
[21% (room air) - 100%]

4. ALL advanced life support strategies received DURING CYCLING today (check ALL that apply)

1. Airway Access ☐ No ☐ Yes → ☐ ETT ☐ Tracheostomy
2. Mechanical Ventilation (MV) ☐ No → None/Spontaneous (e.g. t-mask, venti-mask, nasal prongs)
   ☐ Yes → ☐ Invasive MV (e.g.pressure assist control, volume assist control, pressure support)
   ☐ Non-Invasive MV (e.g. BIPAP, CPAP by mask not ETT or trach, e.g., nocturnal)
3. Other Ventilation Strategy ☐ No ☐ Yes → ☐ ECMO/ECLS ☐ Nitric oxide ☐ High-flow nasal cannula (e.g. AIRVO, Optiflow) ☐ Other (specify)
4. Vasopressor / Inotrope infusions *(e.g., dopamine, norepinephrine, phenylephrine, epinephrine, milrinone, vasopressin)* ☐ No ☐ Yes _____
5. Dialysis ☐ No ☐ Yes → ☐ Intermittent (IHD) ☐ Continuous (CRRT) ☐ Peritoneal ☐ Sustained low efficiency (SLED) ☐ Other (specify)
6. Femoral Catheter in Situ ☐ No ☐ Yes → ☐ Venous ☐ Arterial ☐ Other (specify) _____

5. CYCLING THERAPY

Session Duration (MIN, tablet; check all that apply)	Mode (Active, Passive)	Pedal Spd. (RPM)	Power (Watts)
5 ☐ >0 and ≤5 mins	☐A ☐P	☐☐	☐☐.☐
10 ☐ >5 and ≤10 mins	☐A ☐P	☐☐	☐☐.☐
20 ☐ >10 and ≤20 mins	☐A ☐P	☐☐	☐☐.☐

Any active cycling ☐ Yes ☐ No

Distance travelled (Bike Tablet) ☐☐.☐☐ (km)

Total therapy time (Bike Tablet) ☐☐:☐☐ (min:sec)

Time active (off motor) (Bike Tablet) ☐ N/A ☐☐:☐☐ (min:sec)

Time passive (on motor) (Bike Tablet) ☐ N/A ☐☐:☐☐ (min:sec)

6. Did cycling finish before 30 minutes? ☐ No ☐ Yes (check ALL that apply)

Patient's request ☐ Tired ☐ Other (specify) _____

Therapist stopped session ☐ Agitation ☐ Cardiovascular (specify) _____ ☐ Respiratory (specify) _____ ☐ Other (specify) _____

Physician stopped session ☐ (specify) _____

Other ☐ (specify) _____

7. Any safety events during cycling therapy?

stop session if any of these events occur: **suspected new unstable/ uncontrolled arrhythmia, concern for MI, cardiac arrest, unplanned extubation

☐ No ☐ Yes ***(complete Safety Events Form 5S)***

8. Cycling session end time (bike take down complete and end of cycling therapy portion of therapy session)

☐☐ : ☐☐ (24h-hr:min)

Comments _____

CYCLE RCT #142 Plate #035

Study Day

Patient ID (site #) 1 (patient #) Coded Patient Initials F L Date (dd/mm/yyyy) 2 0

SAFETY EVENTS (Form 5S)

Complete this form if any safety events occurred during cycling or routine PT/ rehab

Cycling therapy safety events - Did any of the following occur during cycling therapy? (check ALL that apply)
** = stop session if any of these events occur

1. ☐ **Suspected new unstable/ uncontrolled arrhythmia
2. ☐ **Concern for myocardial ischaemia
3. ☐ **Cardiac Arrest
4. ☐ **Unplanned extubation
5. ☐ Bleeding at femoral catheter site attributed to in-bed cycling
6. ☐ New bruising at femoral catheter site attributed to in-bed cycling
7. ☐ Sustained O_2 desaturation below baseline and clinical deterioration attributed to in-bed cycling
8. ☐ Sustained symptomatic bradycardia (<40 bpm) or tachycardia (>140 bpm) and clinical deterioration attributed to in-bed cycling
9. ☐ Sustained hypertension (mean arterial pressure >120 mmHg) and clinical deterioration attributed to in-bed cycling
10. ☐ Removal or dysfunction of intravascular catheter (e.g., central venous catheter, arterial line, dialysis catheter) attributed to in-bed cycling
11. ☐ Other (specify)_____

12. What were the consequences of the safety event(s)?
    - ☐ None
    - ☐ Cycling therapy stopped
    - ☐ Other (specify)_____

Routine PT/rehab safety events - Did any of the following occur during routine PT/ rehab? (check ALL that apply)
** = stop session if any of these events occur

1. ☐ **Suspected new unstable/ uncontrolled arrhythmia
2. ☐ **Concern for myocardial ischaemia
3. ☐ **Cardiac Arrest
4. ☐ **Unplanned extubation
5. ☐ **Fall to knees
6. ☐ Bleeding at femoral catheter site attributed to routine PT/ rehab activities
7. ☐ New bruising at femoral catheter site attributed to routine PT/ rehab activities
8. ☐ Sustained O_2 desaturation below baseline and clinical deterioration attributed to routine PT/ rehab activities
9. ☐ Sustained symptomatic bradycardia (<40 bpm) or tachycardia (>140 bpm) and clinical deterioration attributed to routine PT/ rehab activities
10. ☐ Sustained hypertension (mean arterial pressure >120 mmHg) and clinical deterioration attributed to routine PT/ rehab activities
11. ☐ Removal or dysfunction of intravascular catheter (e.g., central venous catheter, arterial line, dialysis catheter) attributed to routine PT/ rehab activities
12. ☐ Other (specify)_____

13. What were the consequences of the safety event(s)?
    - ☐ None
    - ☐ Routine PT/ rehab stopped
    - ☐ Other (specify)_____

CYCLE RCT #142 **Plate #041** **Visit #040**

Patient ID [ ][ ] 1 [ ][ ][ ] (site #) (patient #) Coded Patient Initials [ ][ ] F L Therapist(s) Initials [ ][ ][ ] F M L [ ][ ][ ] F M L **Test Date** [ ][ ] [ ][ ] [2][0][ ][ ] (dd/mm/yyyy)

STRENGTH AND FUNCTION ASSESSMENT: ICU AWAKENING (SF1)

Reason # not done

1. Assessment (ax) merged with other ax form/ other timepoint (complete q# 1B)
2. Patient did not pass cog. screen. prior to ICU discharge (alive @ discharge)
3. Patient died prior to reaching timepoint
4. Goals of care changed to palliative
5. Patient or Proxy refusal
6. Assessment missed
7. Cognitive issue - patient too sedated/ agitated
8. Cognitive issue - patient unable to follow commands
9. Assessor perceives patient unable to perform due to safety concerns (e.g. physiological or physical)
10. Assessor perceives that patient is likely able to but has a limitation such as pain, lines, amputation, fatigue etc.
11. Other assessment prioritized
12. Other (specify)

1A. Any part of assessment completed/ any clinical data

[ ] Yes (go to 1B)
[ ] No (insert reason # not done, if "other", specify) → [ ][ ]
(specify) _____

1B. Clinical data should apply to the following timepoints (check all)

ICU Awakening [ ] ICU Discharge [ ] 3 D Post-ICU Discharge [ ] Hospital Discharge [ ]

2. STRENGTH (MMT) → Assessor blinded? [ ] Yes [ ] No

[ ][ ] Reason # not done (specify) _____

MUSCLE	RIGHT SCORE	RIGHT Reason # not done	LEFT SCORE	LEFT Reason # not done
1. Shoulder Flexion [P]	[ ][ ] /5	[ ][ ]	[ ][ ] /5	[ ][ ]
2. Shoulder Abduction	[ ][ ] /5	[ ][ ]	[ ][ ] /5	[ ][ ]
3. Elbow Flexion	[ ][ ] /5	[ ][ ]	[ ][ ] /5	[ ][ ]
4. Wrist Extension	[ ][ ] /5	[ ][ ]	[ ][ ] /5	[ ][ ]
5. Hip Flexion	[ ][ ] /5	[ ][ ]	[ ][ ] /5	[ ][ ]
6. Knee Extension [P]	[ ][ ] /5	[ ][ ]	[ ][ ] /5	[ ][ ]
7. Ankle Dorsiflexion	[ ][ ] /5	[ ][ ]	[ ][ ] /5	[ ][ ]

3. SIT TO STAND: ASSISTANCE REQUIRED [P] → Assessor blinded? [ ] Yes [ ] No

[ ][ ] Reason # not done (specify) _____

1. Level of assistance required [P] [ ] ***0 people*** [ ] ***1 person*** [ ] ***2 people (or more)*** [ ] ***Attempted + unable***

2. Location [ ] Bed [ ] Chair → Armrest used? [ ] Yes [ ] No

4. MARCHING ON THE SPOT: CADENCE [P] → Assessor blinded? [ ] Yes [ ] No

[ ][ ] Reason # not done (specify) _____

1. Steps [ ][ ][ ] (#) [ ] ***Attempted + unable (if checked, insert score = "0" in "steps")***

2. Time [ ][ ] : [ ][ ] (mm : sec) = [ ][ ][ ] (seconds)

3. Cadence [P] [ ][ ][ ] **(steps/min)**

Cadence = Steps (#) / Time (seconds) x 60

Marching on the spot instructions

"Once you are in the standing position, we will ask you to march on the spot. We would like you to march on the spot for as long as you can. We are going to record how long you walk for and how many steps you do. The test is designed to record your maximum exercise ability, so it is very important that you march on the spot for as long as you possibly can."
Give standardized encouragement every 10 seconds: "Keep going for as long as you can", "You're doing very well", "Well done". If applicable (ie retest), then: "Last time you performed "the test, you marched for. . and did. . steps."

5. 30 SECOND SIT TO STAND → Assessor blinded? [ ] Yes [ ] No

[ ][ ] Reason # not done (specify) _____

1. Sit to stand repetitions completed [ ][ ] (#) [ ] ***Attempted + unable (if checked, insert score = "0" in "sit to stand repetitions completed")***
2. Level of assistance required [ ] 0 people [ ] 1 person [ ] 2 people (or more)
3. Location [ ] Bed [ ] Chair → Armrest used? [ ] Yes [ ] No

Comments _____

CYCLE RCT #142 **Plate #042** **Visit #040**

Patient ID [ ][ ] 1 [ ][ ][ ] (site #) (patient #) Coded Patient Initials [ ][ ] F L Therapist(s) Initials [ ][ ][ ] F M L [ ][ ][ ] F M L **Test Date** [ ][ ] [ ][ ] 2 0 [ ][ ] (dd/mm/yyyy)

STRENGTH AND FUNCTION ASSESSMENT: ICU DISCHARGE (SF2)

Reason # not done

1. Assessment (ax) merged with other ax form/ other timepoint (complete q# 1B)
2. Patient did not pass cog. screen. prior to ICU discharge (alive @ discharge)
3. Patient died prior to reaching timepoint
4. Goals of care changed to palliative
5. Patient or Proxy refusal
6. Assessment missed
7. Cognitive issue - patient too sedated/ agitated
8. Cognitive issue - patient unable to follow commands
9. Assessor perceives patient unable to perform due to safety concerns (e.g. physiological or physical)
10. Assessor perceives that patient is likely able to but has a limitation such as pain, lines, amputation, fatigue etc.
11. Other assessment prioritized
12. Other (specify)

1A. Any part of assessment completed/ any clinical data

[ ] Yes (go to 1B)
[ ] No (insert reason # not done, if "other", specify)→ [ ][ ]
(specify) _____

1B. Clinical data should apply to the following timepoints (check all)

ICU Awakening [ ] ICU Discharge [ ] 3 D Post-ICU Discharge [ ] Hospital Discharge [ ]

2. STRENGTH (MMT) → Assessor blinded? [ ] Yes [ ] No

[ ][ ] Reason # not done (specify) _____

MUSCLE	RIGHT SCORE	RIGHT Reason # not done	LEFT SCORE	LEFT Reason # not done
1. Shoulder Flexion ^{P}	[ ][ ] /5	[ ][ ]	[ ][ ] /5	[ ][ ]
2. Shoulder Abduction	[ ][ ] /5	[ ][ ]	[ ][ ] /5	[ ][ ]
3. Elbow Flexion	[ ][ ] /5	[ ][ ]	[ ][ ] /5	[ ][ ]
4. Wrist Extension	[ ][ ] /5	[ ][ ]	[ ][ ] /5	[ ][ ]
5. Hip Flexion	[ ][ ] /5	[ ][ ]	[ ][ ] /5	[ ][ ]
6. Knee Extension ^{P}	[ ][ ] /5	[ ][ ]	[ ][ ] /5	[ ][ ]
7. Ankle Dorsiflexion	[ ][ ] /5	[ ][ ]	[ ][ ] /5	[ ][ ]

3. SIT TO STAND: ASSISTANCE REQUIRED ^{P} → Assessor blinded? [ ] Yes [ ] No

[ ][ ] Reason # not done (specify) _____

1. Level of assistance required ^{P} [ ] ***0 people*** [ ] ***1 person*** [ ] ***2 people (or more)*** [ ] ***Attempted + unable***

2. Location [ ] Bed [ ] Chair → Armrest used? [ ] Yes [ ] No

4. MARCHING ON THE SPOT: CADENCE ^{P} → Assessor blinded? [ ] Yes [ ] No

[ ][ ] Reason # not done (specify) _____

1. Steps [ ][ ][ ] (#) [ ] ***Attempted + unable (if checked, insert score = "0" in "steps")***

2. Time [ ][ ] : [ ][ ] = [ ][ ][ ] (mm : sec) (seconds)

3. Cadence ^{P} [ ][ ][ ] **(steps/min)**

Cadence = Steps (#) / Time (seconds) x 60

Marching on the spot instructions

"Once you are in the standing position, we will ask you to march on the spot. We would like you to march on the spot for as long as you can. We are going to record how long you walk for and how many steps you do. The test is designed to record your maximum exercise ability, so it is very important that you march on the spot for as long as you possibly can."
Give standardized encouragement every 10 seconds: "Keep going for as long as you can", "You're doing very well", "Well done". If applicable (ie retest), then: "Last time you performed "the test, you marched for. . and did. . steps."

5. 30 SECOND SIT TO STAND → Assessor blinded? [ ] Yes [ ] No

[ ][ ] Reason # not done (specify) _____

1. Sit to stand repetitions completed [ ][ ] (#) [ ] ***Attempted + unable (if checked, insert score = "0" in "sit to stand repetitions completed")***
2. Level of assistance required [ ] 0 people [ ] 1 person [ ] 2 people (or more)
3. Location [ ] Bed [ ] Chair → Armrest used? [ ] Yes [ ] No

6. 2 MINUTE WALK TEST → Assessor blinded? [ ] Yes [ ] No

[ ][ ] Reason # not done (specify) _____

1. Distance *(1 metre = 3.28 feet)* [ ][ ][ ] (metres) **OR** [ ][ ][ ][ ] (feet) [ ] ***Attempted + unable (if checked, insert score = "0" in "distance")***
2. Level of assistance required [ ] 0 people [ ] 1 person [ ] 2 people (or more)
3. Gait aid used [ ] [#, 1 = None, 2 = Cane or crutches, 3 = Walker, 4 = Other (specify)] (specify) _____

Comments _____

CYCLE RCT #142 **Plate #043** **Visit #040**

Patient ID (site #) 1 (patient #) | Coded Patient Initials F L | Therapist(s) Initials F M L F M L | **Test Date** (dd/mm/yyyy) 2 0

STRENGTH AND FUNCTION ASSESSMENT: 3 DAYS POST-ICU DISCHARGE (SF3)

Reason # not done

1. Assessment (ax) merged with other ax form/ other timepoint (complete q# 1B)
2. Patient did not pass cog. screen. prior to ICU discharge (alive @ discharge)
3. Patient died prior to reaching timepoint
4. Goals of care changed to palliative
5. Patient or Proxy refusal
6. Assessment missed
7. Cognitive issue - patient too sedated/agitated
8. Cognitive issue - patient unable to follow commands
9. Assessor perceives patient unable to perform due to safety concerns (e.g. physiological or physical)
10. Assessor perceives that patient is likely able to but has a limitation such as pain, lines, amputation, fatigue etc.
11. Other assessment prioritized
12. Other (specify)

1A. Any part of assessment completed/ any clinical data

☐ Yes (go to 1B)
☐ No (insert reason # not done, if "other", specify) → ☐☐
(specify) _____

1B. Clinical data should apply to the following timepoints (check all)

ICU Awakening ☐ | ICU Discharge ☐ | 3 D Post-ICU Discharge ☐ | Hospital Discharge ☐

2. STRENGTH (MMT) → Assessor blinded? ☐ Yes ☐ No

☐☐ Reason # not done (specify) _____

MUSCLE	RIGHT SCORE	RIGHT Reason # not done	LEFT SCORE	LEFT Reason # not done
1. Shoulder Flexion [P]	☐☐ /5	☐☐	☐☐ /5	☐☐
2. Shoulder Abduction	☐☐ /5	☐☐	☐☐ /5	☐☐
3. Elbow Flexion	☐☐ /5	☐☐	☐☐ /5	☐☐
4. Wrist Extension	☐☐ /5	☐☐	☐☐ /5	☐☐
5. Hip Flexion	☐☐ /5	☐☐	☐☐ /5	☐☐
6. Knee Extension [P]	☐☐ /5	☐☐	☐☐ /5	☐☐
7. Ankle Dorsiflexion	☐☐ /5	☐☐	☐☐ /5	☐☐

3. SIT TO STAND: ASSISTANCE REQUIRED [P] → Assessor blinded? ☐ Yes ☐ No

☐☐ Reason # not done (specify) _____

1. Level of assistance required [P] ☐ ***0 people*** ☐ ***1 person*** ☐ ***2 people (or more)*** ☐ ***Attempted + unable***

2. Location ☐ Bed ☐ Chair → Armrest used? ☐ Yes ☐ No

4. MARCHING ON THE SPOT: CADENCE [P] → Assessor blinded? ☐ Yes ☐ No

☐☐ Reason # not done (specify) _____

1. Steps ☐☐☐ (#) ☐ ***Attempted + unable (if checked, insert score = "0" in "steps")***

2. Time ☐☐ : ☐☐ = ☐☐☐ (mm : sec) (seconds)

3. Cadence [P] ☐☐☐ **(steps/min)**

Cadence = Steps (#) / Time (seconds) x 60

Marching on the spot instructions

"Once you are in the standing position, we will ask you to march on the spot. We would like you to march on the spot for as long as you can. We are going to record how long you walk for and how many steps you do. The test is designed to record your maximum exercise ability, so it is very important that you march on the spot for as long as you possibly can."
Give standardized encouragement every 10 seconds: "Keep going for as long as you can", "You're doing very well", "Well done". If applicable (ie retest), then: "Last time you performed "the test, you marched for. . and did. . steps."

5. 30 SECOND SIT TO STAND → Assessor blinded? ☐ Yes ☐ No

☐☐ Reason # not done (specify) _____

1. Sit to stand repetitions completed ☐☐ (#) ☐ ***Attempted + unable (if checked, insert score = "0" in "sit to stand repetitions completed")***
2. Level of assistance required ☐ 0 people ☐ 1 person ☐ 2 people (or more)
3. Location ☐ Bed ☐ Chair → Armrest used? ☐ Yes ☐ No

6. 2 MINUTE WALK TEST → Assessor blinded? ☐ Yes ☐ No

☐☐ Reason # not done (specify) _____

1. Distance ***(1 metre = 3.28 feet)*** ☐☐☐ (metres) **OR** ☐☐☐☐ (feet) ☐ ***Attempted + unable (if checked, insert score = "0" in "distance")***
2. Level of assistance required ☐ 0 people ☐ 1 person ☐ 2 people (or more)
3. Gait aid used ☐ [#, 1 = None, 2 = Cane or crutches, 3 = Walker, 4 = Other (specify)] (specify) _____

Comments _____

CYCLE RCT #142 **Plate #044** **Visit #040**

Patient ID [ ][ ] 1 [ ][ ][ ] (site #) (patient #) Coded Patient Initials [ ][ ] F L Therapist(s) Initials [ ][ ][ ] F M L [ ][ ][ ] F M L **Test Date** [ ][ ] [ ][ ] 2 0 [ ][ ] (dd/mm/yyyy)

STRENGTH AND FUNCTION ASSESSMENT: HOSPITAL DISCHARGE (SF4)

Reason # not done

1. Assessment (ax) merged with other ax form/ other timepoint (complete q# 1B)
2. Patient did not pass cog. screen. prior to ICU discharge (alive @ discharge)
3. Patient died prior to reaching timepoint
4. Goals of care changed to palliative
5. Patient or Proxy refusal
6. Assessment missed
7. Cognitive issue - patient too sedated/agitated
8. Cognitive issue - patient unable to follow commands
9. Assessor perceives patient unable to perform due to safety concerns (e.g. physiological or physical)
10. Assessor perceives that patient is likely able to but has a limitation such as pain, lines, amputation, fatigue etc.
11. Other assessment prioritized
12. Other (specify)

1A. Any part of assessment completed/ any clinical data

[ ] Yes (go to 1B)
[ ] No (insert reason # not done, if "other", specify) → [ ][ ]
(specify) _____

1B. Clinical data should apply to the following timepoints (check all)

ICU Awakening [ ] ICU Discharge [ ] 3 D Post-ICU Discharge [ ] Hospital Discharge [ ]

2. STRENGTH (MMT) → Assessor blinded? [ ] Yes [ ] No

[ ][ ] Reason # not done (specify) _____

MUSCLE	RIGHT SCORE	RIGHT Reason # not done	LEFT SCORE	LEFT Reason # not done
1. Shoulder Flexion ^{P}	[ ]/5	[ ][ ]	[ ]/5	[ ][ ]
2. Shoulder Abduction	[ ]/5	[ ][ ]	[ ]/5	[ ][ ]
3. Elbow Flexion	[ ]/5	[ ][ ]	[ ]/5	[ ][ ]
4. Wrist Extension	[ ]/5	[ ][ ]	[ ]/5	[ ][ ]
5. Hip Flexion	[ ]/5	[ ][ ]	[ ]/5	[ ][ ]
6. Knee Extension ^{P}	[ ]/5	[ ][ ]	[ ]/5	[ ][ ]
7. Ankle Dorsiflexion	[ ]/5	[ ][ ]	[ ]/5	[ ][ ]

3. SIT TO STAND: ASSISTANCE REQUIRED ^{P} → Assessor blinded? [ ] Yes [ ] No

[ ][ ] Reason # not done (specify) _____

1. Level of assistance required ^{P} [ ] ***0 people*** [ ] ***1 person*** [ ] ***2 people (or more)*** [ ] ***Attempted + unable***

2. Location [ ] Bed [ ] Chair → Armrest used? [ ] Yes [ ] No

4. MARCHING ON THE SPOT: CADENCE ^{P} → Assessor blinded? [ ] Yes [ ] No

[ ][ ] Reason # not done (specify) _____

1. Steps [ ][ ][ ] (#) [ ] ***Attempted + unable (if checked, insert score = "0" in "steps")***

2. Time [ ][ ] : [ ][ ] = [ ][ ][ ] (mm : sec) (seconds)

3. Cadence ^{P} [ ][ ][ ] **(steps/min)**

Cadence = Steps (#) / Time (seconds) x 60

Marching on the spot instructions

"Once you are in the standing position, we will ask you to march on the spot. We would like you to march on the spot for as long as you can. We are going to record how long you walk for and how many steps you do. The test is designed to record your maximum exercise ability, so it is very important that you march on the spot for as long as you possibly can."
Give standardized encouragement every 10 seconds: "Keep going for as long as you can", "You're doing very well", "Well done". If applicable (ie retest), then: "Last time you performed "the test, you marched for. . and did. . steps."

5. 30 SECOND SIT TO STAND → Assessor blinded? [ ] Yes [ ] No

[ ][ ] Reason # not done (specify) _____

1. Sit to stand repetitions completed [ ][ ] (#) [ ] ***Attempted + unable (if checked, insert score = "0" in "sit to stand repetitions completed")***
2. Level of assistance required [ ] 0 people [ ] 1 person [ ] 2 people (or more)
3. Location [ ] Bed [ ] Chair → Armrest used? [ ] Yes [ ] No

6. 2 MINUTE WALK TEST → Assessor blinded? [ ] Yes [ ] No

[ ][ ] Reason # not done (specify) _____

1. Distance *(1 metre = 3.28 feet)* [ ][ ][ ] (metres) **OR** [ ][ ][ ][ ] (feet) [ ] ***Attempted + unable (if checked, insert score = "0" in "distance")***
2. Level of assistance required [ ] 0 people [ ] 1 person [ ] 2 people (or more)
3. Gait aid used [ ] [#, 1 = None, 2 = Cane or crutches, 3 = Walker, 4 = Other (specify)] (specify) _____

Comments _____

CYCLE RCT #142 **Plate #051** **Visit #090**

Patient ID [ ][ ] 1 [ ][ ][ ] (site #) (patient #) Coded Patient Initials [ ][ ] F L Assessor Initials [ ][ ] F L Date of Assessment [ ][ ] [ ][ ] 2 0 [ ][ ] (dd/mm/yyyy)

ICU AWAKENING: INTENSIVE CARE PSYCHOLOGICAL ASSESSMENT TOOL (IPAT) (Form RC 1)

1. Was any clinical data collected at this timepoint?

☐ Yes
☐ No (insert reason #, if "other", specify) → [ ][ ]
(specify) _____

Reason # not done

1. (Intentionally omitted)
2. Patient did not pass cog. screen. prior to ICU discharge (alive @ discharge)
3. Patient died prior to reaching timepoint
4. Goals of care changed to palliative
5. Patient or Proxy refusal
6. Assessment missed
7. Cognitive issue - patient too sedated/agitated
8. Cognitive issue - patient unable to follow commands
9. (Intentionally omitted)
10. (Intentionally omitted)
11. Other assessment prioritized
12. Other (specify)

"I would like to ask you some questions about your stay in intensive care, and how you've been feeling in yourself. These feelings can be an important part of your recovery. To answer, please circle the answer that is closest to how you feel, or answer in any way you are able to (e.g. by speaking or pointing)"

	Since you've been in Intensive care:	A	B	C
1	Has it been hard to communicate?	No ☐	Yes, a bit ☐	Yes, a lot ☐
2	Has it been difficult to sleep?	No ☐	Yes, a bit ☐	Yes, a lot ☐
3	Have you been feeling tense?	No ☐	Yes, a bit ☐	Yes, a lot ☐
4	Have you been feeling sad?	No ☐	Yes, a bit ☐	Yes, a lot ☐
5	Have you been feeling panicky?	No ☐	Yes, a bit ☐	Yes, a lot ☐
6	Have you been feeling hopeless?	No ☐	Yes, a bit ☐	Yes, a lot ☐
7	Have you felt disoriented (not quite sure where you are)?	No ☐	Yes, a bit ☐	Yes, a lot ☐
8	Have you had hallucinations (seen or heard things you suspect were not really there)?	No ☐	Yes, a bit ☐	Yes, a lot ☐
9	Have you felt that people were *deliberately* trying to harm or hurt you?	No ☐	Yes, a bit ☐	Yes, a lot ☐
10	Do upsetting memories of intensive care keep coming into your mind?	No ☐	Yes, a bit ☐	Yes, a lot ☐

Do you have any comments to add in relation to any of the answers?

_____

SCORING
Any answer in column A = 0 points
Any answer in column B = 1 point
Any answer in column C = 2 points

Sum up the scores of each item for a total IPAT score out of 20
Cut-off point ≥ 7 indicates patient at risk

TOTAL SCORE [ ][ ] **/20**

Approximate time to complete assessment? [ ][ ] **(min)**

Patient intubated during assessment? ☐ Yes ☐ No

Location of ax? ☐ ICU ☐ Other (specify) _____

CYCLE RCT #142 **Plate #052** **Visit #090**

Patient ID [ ][ ] (site #) 1 [ ][ ][ ] (patient #) Coded Patient Initials [ ][ ] F L Assessor Initials [ ][ ] F L Date of Assessment [ ][ ] [ ][ ] 2 0 [ ][ ] (dd/mm/yyyy)

RESEARCH COORDINATOR ASSESSMENT: ICU DISCHARGE (Form RC 2.1 of 2)

1. Was the patient alive at ICU discharge?

☐ **Yes**
☐ **No** (do not collect ADL data; go to 3A)

2. Activities of Daily Living (ADL) (Ask the patient the following AND/OR review chart regarding their current function; check ONE box per activity)

ACTIVITY	INDEPENDENT	DEPENDENT
BATHING (e.g. sponge, shower, or tub)	☐ Assistance only in bathing a single part (as back or disabled extremity), or bathes self completely	☐ Assistance in bathing more than one part of body, or assistance in getting in or out of tub, or does not bathe self
DRESSING	☐ Gets clothes from closets and drawers, and puts on clothes, outer garments and braces, and manages fasteners (act of tying shoes excluded)	☐ Does not dress self, or remains partially undressed
GOING to the TOILET	☐ Gets to toilet, gets on-and-off toilet, arranges clothes, and cleans organs of excretion (may manage own bedpan used at night and may not be using mechanical supports)	☐ Uses bedpan or commode, or receives assistance in getting to and using toilet
TRANSFER	☐ Moves in and out of bed independently, and moves in and out of chair independently (may or may not use mechanical supports)	☐ Assistance in moving in-and-out of bed and/or chair; does not perform one or more transfers
CONTINENCE	☐ Urination and defecation entirely self-controlled	☐ Partial or total incontinence in urination or defecation, or partial or total control by enemas, catheters, or regulated use of urinals &/or bedpans
FEEDING	☐ Gets food from plate or its equivalent into mouth. Note: Precutting of meat and preparation of food, as buttering bread are excluded	☐ Assistance in the act of feeding, or does not eat at all or parenteral (e.g. intravenous TPN) feeding

Reason # not done

1. Assessment (ax) merged with other ax form/ other timepoint (complete q# 3B)
2. (Intentionally omitted)
3. Patient died prior to reaching timepoint
4. Goals of care changed to palliative
5. Patient or Proxy refusal
6. Assessment missed
7. Cognitive issue - patient too sedated/agitated
8. Cognitive issue - patient unable to follow commands
9. (Intentionally omitted)
10. (Intentionally omitted)
11. Other assessment prioritized
12. Other (specify)_____

3A. Any part of assessment completed/ any clinical data

☐ Yes (go to 3B)
☐ No (insert reason # not done, if "other", specify) → [ ][ ]
(specify)_____

3B. Clinical data should apply to the following timepoints (check all)

ICU Discharge ☐ Hospital Discharge ☐

4. Patient-Reported Functional Scale (Ask the patient the following questions; insert all activity scores into table below; do not score based on chart review)

[ ][ ] Reason # not done (specify) _____

Instructions: *"I'm going to ask you about how well you think you can do 6 activities. Compared to before you got sick, can you rate how well you can do each of these activities? Today, do you, or would you have difficulty with the following items? Please point to the number which best describes your ability. 10 = as well as you could before the ICU, and 0 = unable to do this activity right now." (If the patient reports the activity is not relevant to them, please state, "If you are not doing this now, do you imagine you would have any difficulty?")*

Unable to perform activity 0 1 2 3 4 5 6 7 8 9 10 **Able to perform activity at same level as before ICU admission**

ACTIVITY	SCORE
1. Rolling in bed	[ ][ ] /10
2. Moving from lying in the bed to sitting at the edge of the bed	[ ][ ] /10
3. Moving from sitting to standing	[ ][ ] /10
4. Transferring from bed to chair	[ ][ ] /10
5. Walking the length of a football field (100 m / 110 yards)	[ ][ ] /10
6. Climbing 1 flight of stairs (10 steps)	[ ][ ] /10
SUM TOTAL	[ ][ ] /60
FINAL SCORE (sum total / 6)	[ ][ ].[ ]

CYCLE RCT #142 **Plate #053** **Visit #090**

Patient ID [ ][ ] 1 [ ][ ][ ] (site #) (patient #) Coded Patient Initials [ ][ ] F L Assessor Initials [ ][ ] F L Date of Assessment [ ][ ] [ ][ ] 2 0 [ ][ ] (dd/mm/yyyy)

RESEARCH COORDINATOR ASSESSMENT: ICU DISCHARGE (Form RC 2.2 of 2)

Reason # not done

1. Assessment (ax) merged with other ax form/ other timepoint (complete q# 3B)
2. (Intentionally omitted)
3. Patient died prior to reaching timepoint
4. Goals of care changed to palliative
5. Patient or Proxy refusal
6. Assessment missed
7. Cognitive issue - patient too sedated/agitated
8. Cognitive issue - patient unable to follow commands
9. (Intentionally omitted)
10. (Intentionally omitted)
11. Other assessment prioritized
12. Other (specify)_____

5. EQ-5D: Descriptive System: Today's Perception

[ ][ ] Reason # not done (specify) _____

Instructions: Read the 5 descriptions from each heading *to the patient*

"Under each heading, tick 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 [ ]

6. EQ-5D: Visual Analogue Scale: Today's Perception

[ ][ ] Reason # not done (specify) _____

Instructions: Read to the following to the patient:

"We would like to know how good or bad your health is TODAY."

This scale is numbered from 0 - 100.

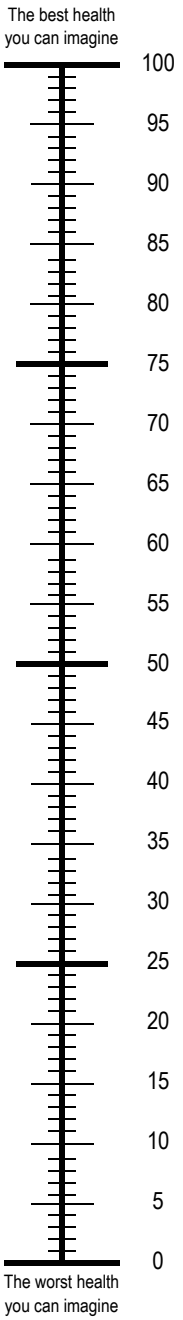
100 means the best health you can imagine
0 means the worst health you can imagine

Mark an X on the scale to indicate how your health is TODAY.

Now, please write the number you marked on the scale in the box below."

YOUR HEALTH SCORE TODAY

[ ][ ][ ]



CYCLE RCT #142 **Plate #054** **Visit #090**

Patient ID [ ][ ] 1 [ ][ ][ ] (site #) (patient #) Coded Patient Initials [ ][ ] F L Assessor Initials [ ][ ] F L Date of Assessment [ ][ ] [ ][ ] 2 0 [ ][ ] (dd/mm/yyyy)

RESEARCH COORDINATOR ASSESSMENT: HOSPITAL DISCHARGE (Form RC 3.1 of 4)

1. Was the patient alive at hospital discharge?

☐ **Yes**

☐ **No** (do not collect ADL and Frailty data; go to 4A)

2. Activities of Daily Living (ADL) (Ask the patient the following AND/OR review chart regarding their current function; check ONE box per activity)

ACTIVITY	INDEPENDENT	DEPENDENT
BATHING (e.g. sponge, shower, or tub)	☐ Assistance only in bathing a single part (as back or disabled extremity), or bathes self completely	☐ Assistance in bathing more than one part of body, or assistance in getting in or out of tub, or does not bathe self
DRESSING	☐ Gets clothes from closets and drawers, and puts on clothes, outer garments and braces, and manages fasteners (act of tying shoes excluded)	☐ Does not dress self, or remains partially undressed
GOING to the TOILET	☐ Gets to toilet, gets on-and-off toilet, arranges clothes, and cleans organs of excretion (may manage own bedpan used at night and may not be using mechanical supports)	☐ Uses bedpan or commode, or receives assistance in getting to and using toilet
TRANSFER	☐ Moves in and out of bed independently, and moves in and out of chair independently (may or may not use mechanical supports)	☐ Assistance in moving in-and-out of bed and/or chair; does not perform one or more transfers
CONTINENCE	☐ Urination and defecation entirely self-controlled	☐ Partial or total incontinence in urination or defecation, or partial or total control by enemas, catheters, or regulated use of urinals &/or bedpans
FEEDING	☐ Gets food from plate or its equivalent into mouth. Note: Precutting of meat and preparation of food, as buttering bread are excluded	☐ Assistance in the act of feeding, or does not eat at all or parenteral (e.g. intravenous TPN) feeding

3. Hospital Discharge Admission Frailty Scale (Considering the patient's status at hospital discharge, please select the highest score from the descriptions below from 1 to 9. If the patient has characteristics from higher descriptors, then please report the highest score)

FRAILTY SCORE ☐ **(1-9)**

1. VERY FIT: People who are robust, active, energetic and motivated. These people commonly exercise regularly. They are among the fittest for their age.

2. WELL: People who have **no active disease symptoms** but are less fit than category 1. Often, they exercise or are very **active occasionally**,e.g. seasonally

3. MANAGING WELL: People whose **medical problems are well controlled,** but are **not regularly active** beyond routine walking.

4. VULNERABLE: While **not dependent** on others for daily help, often **symptoms limit activities.** A common complaint is being "slowed up",and/or being tired during the day.

5. MILDLY FRAIL: These people often have **more evident slowing**, and need help in **high order IADLS** (finances, transportation, heavy housework, medications). Typically, mild frailty progressively impairs shopping and walking outside alone, meal preparation and housework.

6. MODERATELY FRAIL: People who need help with **all outside activities** and with **keeping house**. Inside, they often have problems with stairs and need **help with bathing** and might need minimal assistance (cuing, standby) with dressing.

7. SEVERELY FRAIL: **Completely dependent for personal care**, from whatever cause (physical or cognitive). Even so, they seem stable and not at high risk of dying (within ~ 6 months).

8. VERY SEVERELY FRAIL: Completely dependent, approaching the end of life. Typically, they could not recover even from a minor illness.

9. TERMINALLY ILL: Approaching the end of life. This category applies to people with **a life expectancy <6 months**, who are **not otherwise evidently frail.**

Scoring frailty in people with dementia: The degree of frailty corresponds to the degree of dementia.

Common **symptoms in mild dementia** include forgetting the details of a recent event, though still remembering the event itself, repeating the same question/story and social withdrawal.

In **moderate dementia**, recent memory is very impaired, even though they seemingly can remember their past life events well. They can do personal care with prompting.

In **severe dementia**, they cannot do personal care without help.

CYCLE RCT #142 **Plate #055** **Visit #090**

Patient ID [ ][ ] 1 [ ][ ][ ] (site #) (patient #) Coded Patient Initials [ ][ ] F L Assessor Initials [ ][ ] F L Date of Assessment [ ][ ] [ ][ ] 2 0 [ ][ ] (dd/mm/yyyy)

RESEARCH COORDINATOR ASSESSMENT: HOSPITAL DISCHARGE (Form RC 3.2 of 4)

Reason # not done

1. Assessment (ax) merged with other ax form/ other timepoint (complete q# 4B)
2. (Intentionally omitted)
3. Patient died prior to reaching timepoint
4. Goals of care changed to palliative
5. Patient or Proxy refusal
6. Assessment missed
7. Cognitive issue - patient too sedated/agitated
8. Cognitive issue - patient unable to follow commands
9. (Intentionally omitted)
10. (Intentionally omitted)
11. Other assessment prioritized
12. Other (specify)_____

4A. Any part of assessment completed/ any clinical data

☐ Yes (go to 4B)
☐ No (insert reason # not done, if "other", specify) → [ ][ ]
(specify)_____

4B. Clinical data should apply to the following timepoints (check all)

ICU Discharge ☐ Hospital Discharge ☐

5. Patient-Reported Functional Scale (Ask the patient the following questions; insert all activity scores into table below; do not score based on chart review)

[ ][ ] Reason # not done (specify) _____

Instructions: *"I'm going to ask you about how well you think you can do 6 activities. Compared to before you got sick, can you rate how well you can do each of these activities? Today, do you, or would you have difficulty with the following items? Please point to the number which best describes your ability. 10 = as well as you could before the ICU, and 0 = unable to do this activity right now." (If the patient reports the activity is not relevant to them, please state, "If you are not doing this now, do you imagine you would have any difficulty?")*

Unable to perform activity 0 1 2 3 4 5 6 7 8 9 10 **Able to perform activity at same level as before ICU admission**

ACTIVITY	SCORE
1. Rolling in bed	[ ][ ] /10
2. Moving from lying in the bed to sitting at the edge of the bed	[ ][ ] /10
3. Moving from sitting to standing	[ ][ ] /10
4. Transferring from bed to chair	[ ][ ] /10
5. Walking the length of a football field (100 m / 110 yards)	[ ][ ] /10
6. Climbing 1 flight of stairs (10 steps)	[ ][ ] /10
SUM TOTAL	[ ][ ] /60
FINAL SCORE (sum total / 6)	[ ][ ].[ ]

CYCLE RCT #142 **Plate #056** **Visit #090**

Patient ID [ ][ ] 1 [ ][ ][ ] (site #) (patient #) Coded Patient Initials [ ][ ] F L Assessor Initials [ ][ ] F L Date of Assessment [ ][ ] [ ][ ] 2 0 [ ][ ] (dd/mm/yyyy)

RESEARCH COORDINATOR ASSESSMENT: HOSPITAL DISCHARGE (Form RC 3.3 of 4)

Reason # not done

1. Assessment (ax) merged with other ax form/ other timepoint (complete q# 4B)
2. (Intentionally omitted)
3. Patient died prior to reaching timepoint
4. Goals of care changed to palliative
5. Patient or Proxy refusal
6. Assessment missed
7. Cognitive issue - patient too sedated/agitated
8. Cognitive issue - patient unable to follow commands
9. (Intentionally omitted)
10. (Intentionally omitted)
11. Other assessment prioritized
12. Other (specify)_____

6. EQ-5D: Descriptive System: Today's Perception

[ ][ ] Reason # not done (specify) _____

Instructions: Read the 5 descriptions from each heading *to the patient*

"Under each heading, tick 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 [ ]

7. EQ-5D: Visual Analogue Scale: Today's Perception

[ ][ ] Reason # not done (specify) _____

Instructions: Read to the following to the patient:

"We would like to know how good or bad your health is TODAY."

This scale is numbered from 0 - 100.

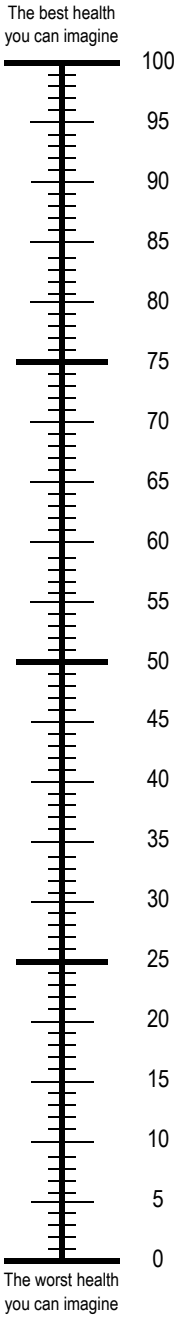
100 means the best health you can imagine
0 means the worst health you can imagine

Mark an X on the scale to indicate how your health is TODAY.

Now, please write the number you marked on the scale in the box below."

YOUR HEALTH SCORE TODAY

[ ][ ][ ]



CYCLE RCT #142 **Plate #057** **Visit #090**

Patient ID [ ][ ] 1 [ ][ ][ ] (site #) (patient #) Coded Patient Initials [ ][ ] F L Assessor Initials [ ][ ] F L Date of Assessment [ ][ ] [ ][ ] 2 0 [ ][ ] (dd/mm/yyyy)

RESEARCH COORDINATOR ASSESSMENT: HOSPITAL DISCHARGE (Form RC 3.4 of 4)

Reason # not done

1. Assessment (ax) merged with other ax form/ other timepoint (complete q# 4B)
2. (Intentionally omitted)
3. Patient died prior to reaching timepoint
4. Goals of care changed to palliative
5. Patient or Proxy refusal
6. Assessment missed
7. Cognitive issue - patient too sedated/agitated
8. Cognitive issue - patient unable to follow commands
9. (Intentionally omitted)
10. (Intentionally omitted)
11. Other assessment prioritized
12. Other (specify)_____

8. EQ-5D: Descriptive System: Pre-hospital perception

[ ][ ] Reason # not done (specify)_____

Instructions: Read the 5 descriptions from each domain to the patient and ask them to select ONE descriptor.

"Imagine a normal day before you were admitted to the hospital... Thinking about this day how would you rate your health? Under each heading, please tick ONE box that best describes your health on a normal day."

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 [ ]

9. EQ-5D: Visual Analogue Scale: Pre-hospital perception

[ ][ ] Reason # not done (specify)_____

Instructions: Read to the following to the patient:

"Imagine a normal day before you were admitted to the hospital. We would like to know how good or bad your health is on a normal day.

This scale is numbered from 0 - 100.

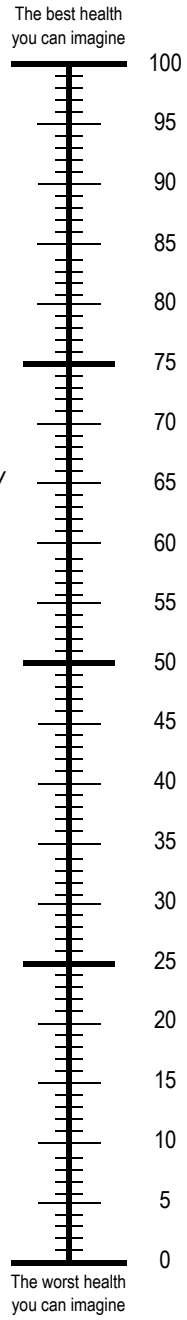
100 means the best health you can imagine
0 means the worst health you can imagine

Thinking about this day, mark an X on the scale to indicate how you would rate your health on a normal day

Now, please write the number you marked on the scale in the box below."

YOUR HEALTH SCORE ON A NORMAL DAY

[ ][ ][ ]



CYCLE RCT #142 **Plate #060**

(Week #)
(01 - 26; stop collection at week 26) 1

Patient ID (site #) 1 (patient #)

Coded Patient Initials F L

PT/ REHABILITATION POST-LAST STUDY DAY (Form 6)

Record patient's PT treatment received once Daily Data Form 4 collection has stopped (patient reached last study day) until hospital d/c OR until patient has been discharged from PT/rehabilitation services OR once 26 weeks of form 6 data collection completed.

Date First Column (dd/mm/yyyy) 20

Date Last Column (dd/mm/yyyy) 20

Last Form 6? ☐ No ☐ Yes

Day of week							
Date (d/m/y)	First						Last
Patient discharged from PT/rehab service *(Stop data collection)*	☐	☐	☐	☐	☐	☐	☐
Patient refused PT/rehab	☐	☐	☐	☐	☐	☐	☐
PT/rehab not received	☐	☐	☐	☐	☐	☐	☐
Rehab Therapy Treatment Received ***[check ALL activities performed during the treatment session (with or without assistance)]***							
Passive	☐0	☐0	☐0	☐0	☐0	☐0	☐0
Activity in bed	☐1	☐1	☐1	☐1	☐1	☐1	☐1
Passive to chair	☐2	☐2	☐2	☐2	☐2	☐2	☐2
Sit @ E.O.B.	☐3	☐3	☐3	☐3	☐3	☐3	☐3
Standing	☐4	☐4	☐4	☐4	☐4	☐4	☐4
Tx bed to chair	☐5	☐5	☐5	☐5	☐5	☐5	☐5
M.O.S. 2 steps/ft	☐6	☐6	☐6	☐6	☐6	☐6	☐6
Walk Ax2	☐7	☐7	☐7	☐7	☐7	☐7	☐7
Walk Ax1	☐8	☐8	☐8	☐8	☐8	☐8	☐8
Walk indep w/ aid	☐9	☐9	☐9	☐9	☐9	☐9	☐9
Walk indep no aid	☐10	☐10	☐10	☐10	☐10	☐10	☐10
Stairs	☐11	☐11	☐11	☐11	☐11	☐11	☐11
Chest PT	☐12	☐12	☐12	☐12	☐12	☐12	☐12

Comments _____

Definitions: Physiotherapy / Rehabilitation Treatment Received

0) Passively moved by staff (includes passive cycling only)

1) Any activity in bed, but not moving out of or over edge of bed (includes cycling)

2) Passively moved to chair (no standing or sitting at edge of bed)

3) Actively sitting over side of bed with some trunk control trunk control (may be assisted)

4) Standing

5) Transferring from bed to chair

6) Marching on the spot (at bedside; ≥ 2steps/foot)

7) Walking with assistance of 2 or more people (≥5m)

8) Walking with assistance of 1 person (≥5m)

9) Walking independently with gait aid (≥5m)

10) Walking independently without gait aid (≥5m)

11) Walking up and down stairs

12) Chest PT / Airway Clearance

CYCLE RCT #142 **Plate #070** **Visit #090**

Patient ID [ ][ ] 1 [ ][ ][ ] (site #) (patient #) Coded Patient Initials [ ][ ] F L Assessor Initials [ ][ ] F L

90 DAY FOLLOW-UP QUESTIONNAIRE (Form RC 4.1 of 13)

Assessment Collection Window:
83 - 120 days post-randomization (ideal = day 90)

SDM/ LAR Can Provide Data For:
Section A = ALL Parts
Section B = ONLY Part 1 "Frailty" (Parts 2, 3, 4 = completed via patient interview or SDM/LAR with patient input)

1. **Date of randomization** [ ][ ] [ ][ ] 2 0 [ ][ ] (dd/mm/yyyy)
2. **Date of 90 days post-randomization** [ ][ ] [ ][ ] 2 0 [ ][ ] (dd/mm/yyyy)
3. **Date range of assessment** [ ][ ] [ ][ ] 2 0 [ ][ ] → [ ][ ] [ ][ ] 2 0 [ ][ ] (dd/mm/yyyy)
   (If start date = end date, enter same date in both fields) (start date) (end date)

4. **At time of follow-up/ date of assessment, was the patient alive?**

☐ Unknown (only choose this if directed by the methods centre; stop here)

☐ No → **Record date of death:** [ ][ ] [ ][ ] 2 0 [ ][ ] (dd/mm/yyyy)

→ Before they died, did the patient spend any time in the following locations:
Home/Retirement Home, Assisted Living Facility, Nursing Home, Long Term Care Facility, Chronic Care Facility

☐ No → **(Stop here)**

☐ Yes → **(Complete Section A only; go to page 4.2)**

☐ Yes → At the time of follow-up, did the patient spend any time in the following locations since hospital discharge:
Home/Retirement Home, Assisted Living Facility, Nursing Home, Long Term Care Facility, Chronic Care Facility

☐ No → **(Complete Section B only; go to page 4.2)**

☐ Yes → **(Complete Sections A + B; go to page 4.2)**

***Section A does not need to be completed if the patient has only spent time in any the following locations since randomization: hospital, inpatient rehabilitation, long term acute care, skilled nursing facility**

****If the patient has spent time in locations not listed above, and you are unsure if section A should be completed, please contact the methods centre for guidance prior to starting the assessment.**

CYCLE RCT #142 **Plate #071** **Visit #090**

Patient ID [ ][ ] 1 [ ][ ][ ] (site #) (patient #) Coded Patient Initials [ ][ ] F L

90 DAY FOLLOW-UP QUESTIONNAIRE (Form RC 4.2 of 13)

Introduction

"Hello **(*insert name of patient/SDM/LAR)***, my name is **(*insert name of research personnel*)**. I am calling from (***insert name of institution***) regarding the CYCLE research study that you participated in during your stay in the Intensive Care Unit in **(*insert ICU admission month*)**. This study is investigating the use of in-bed cycling for patients requiring a breathing machine in the ICU. I am calling you today to follow-up to see how you are doing 3 months after you began in the study. I was hoping I could speak with you for a few minutes to ask you some questions about your health and function. This should take no longer than ___ minutes. Would that be okay?"

*If **yes,** continue with the follow-up questionnaire.*

*If **no,** ask them if there is a better time to complete the interview. Re-inforce the importance of the follow-up interview (i.e. helps us to determine if the treatment you received was beneficial in the long-term, provides you with information regarding your recovery, helps us learn the best way to care for future patients in the ICU like yourself) and the timelines associated with the follow-up call. If the patient still does not want to complete the interview, thank them for their time and end the call.*

Record who is completing the assessment (i.e. patient or SDM/ LAR) and whether or not consent was obtained. If assessment is not being completed, record the reason not done code on the following page.

6. Assessment being completed by (check ALL):
(*If being completed by SDM/LAR with patient input, check both boxes)* ☐ Patient ☐ SDM/ LAR

7. Patient/SDM/LAR consents to assessment: ☐ Yes ☐ No (specify) _____

_____

If you are leaving a voicemail, ensure not to disclose PHI or breach PHIPA rules: "Hello this message is for **(*insert name of patient)***. My name is ***(insert name of research personnel)*** and I am calling from **(*insert name of institution)*** regarding the CYCLE research study that you have been involved in since your stay in hospital. I am calling to follow-up with you to see how you are doing since leaving the hospital and to ask you some questions. Please give me a call back at your earliest convenience. You can reach me at **(*insert phone number here*)**. Thank you."

If you are told that a study participant has died, express your condolences as below: "I am very sorry to hear that **(*insert name of patient)*** has passed away. This must be a difficult time for you." *Allow the contact to express themselves. When appropriate, ask the contact if you can continue to ask them some questions regarding the study. Complete section A of questionnaire only.* Closing the call: "Thank you very much for taking the time to talk with me. I am very sorry to hear about your loss. Take care."

If you are calling an alternate contact person: "(*insert patient name)* provided your name as a person who we could call to try to reach him/her. I hope that you can help us to contact him/her."

If patient states they have never heard of study and don't know why they were enrolled: Politely explain the study and why they were enrolled. Ask them for consent to continue with the assessment: "While you were in the ICU and on a breathing machine, your family member or friend enrolled you in the CYCLE study. The CYCLE study investigates whether patients who receive routine physiotherapy and in-bed cycling while on a breathing machine in the ICU do better than those who receive routine physiotherapy only. We want to learn about how you have been doing since your discharge from the hospital. We will be asking you some questions about your health care needs, quality of life, and physical function. Your answers to these questions will be kept confidential. Do you have any questions? Is it okay if I continue with the questionnaire?"

CYCLE RCT #142 **Plate #072** **Visit #090**

Patient ID [ ][ ] 1 [ ][ ][ ] (site #) (patient #) Coded Patient Initials [ ][ ] F L Date of Assessment [ ][ ] [ ][ ] 2 0 [ ][ ] (dd/mm/yyyy)

90 DAY FOLLOW-UP QUESTIONNAIRE (Form RC 4.3 of 13)

SECTION A: UTILIZATION

Please complete this section if patient spent time in any of the following locations since date of randomization: Home/ Retirement Home, Assisted Living Facility, Nursing Home, Long Term Care Facility, Chronic Care Facility

Reason # not done
1 = Unable to contact patient or SDM/LAR
2 = Patient/ SDM/ LAR does not provide consent (patient/ SDM /LAR contacted)
3 = Patient/ SDM/ LAR refusal (consent acquired)
4 = Assessor perceives patient unable to perform and SDM/ LAR not available
5 = Other (specify)_____

[ ][ ] Reason # not done (if "other", specify)
_____
_____

"Firstly, I would like to ask you some questions about your health care needs and ability to return to your daily activities since being discharged from hospital. If you have information recorded on the patient log provided to you at hospital discharge it would be helpful for you to have this on hand as we go through the questions."

Part 1: Patient Disposition and Living Facilities

1.1 Where are you currently living (if patient not alive at time of follow-up, where were they living previously?

- [ ] Unknown
- [ ] Home (independent)
- [ ] Home (w/ home care)
- [ ] Home (w/unpaid caregiver assistance)
- [ ] Retirement Home (independent)
- [ ] Assisted Living Facility (mostly independent)
- [ ] Nursing Home/ Long Term Care Facility
- [ ] Chronic Care Facility/ Complex Continuing Care/ Skilled Nursing Facility
- [ ] Long Term Acute Care (LTAC)
- [ ] Inpatient Rehabilitation
- [ ] Acute Care Hospital
- [ ] Other (specify) _____

1.2 Marital status (check ONE box)

[ ] Unknown [ ] Single [ ] Married or Common law [ ] Separated or Divorced [ ] Other (specify)_____

1.3 Since your hospital discharge, have you had any admissions to a <u>long term care facility</u>?

[ ] Unknown [ ] No [ ] Yes → How many days? [ ][ ] (# days) [ ] Unknown

1.4 Since your hospital discharge, have you spent any time in a <u>retirement home</u>?

[ ] Unknown [ ] No [ ] Yes → How many days? [ ][ ] (# days) [ ] Unknown

1.5 Since your hospital discharge, have you spent any time in an <u>assisted living facility?</u>

[ ] Unknown [ ] No [ ] Yes → How many days? [ ][ ] (# days) [ ] Unknown

1.6 Since your hospital discharge, have you spent any time in/ in a <u>chronic care facility/ complex continuing care/ skilled nursing facility</u>?

[ ] Unknown [ ] No [ ] Yes → How many days? [ ][ ] (# days) [ ] Unknown

1.7 Since your hospital discharge, have you spent any time in <u>long term acute care (LTAC)</u>?

[ ] Unknown [ ] No [ ] Yes → How many days? [ ][ ] (# days) [ ] Unknown

1.8 Since your hospital discharge, have you spent any time in an <u>inpatient rehab</u>?

[ ] Unknown [ ] No [ ] Yes → How many days? [ ][ ] (# days) [ ] Unknown

1.9 Since your hospital discharge, have you spent any time in any other locations not listed above (e.g. drug rehab facility)?

[ ] Unknown [ ] No [ ] Yes (specify) _____

Part 2: Emergency Room Visits and Hospitalizations

2.1 Since your hospital discharge, have you visited an emergency room for any reason?

[ ] Unknown [ ] No [ ] Yes → How many times? [ ][ ] (# visits) [ ] Unknown

[*Interviewer: For each emergency room visit, ask the patient the reason for the visit*]

VISIT #1: [ ] Unknown Reason: _____

VISIT #2: [ ] Unknown Reason: _____

VISIT #3: [ ] Unknown Reason: _____

CYCLE RCT #142 **Plate #073** **Visit #090**

Patient ID [ ][ ] 1 [ ][ ][ ] (site #) (patient #) Coded Patient Initials [ ][ ] F L Date of Assessment [ ][ ] [ ][ ] 2 0 [ ][ ] (dd/mm/yyyy)

90 DAY FOLLOW-UP QUESTIONNAIRE (Form RC 4.4 of 13)

2.2 Since your hospital discharge, have you been admitted to a hospital overnight, for any reason?

☐ Unknown

☐ No ☐ Yes → How many times? [ ][ ] (# admissions) ☐ Unknown

[*Interviewer: For each hospitalization, ask the patient the reason for the hospitalization, any major surgeries/procedures performed, where they were discharged to, admission and discharge dates (or estimated length of stay if not known), and number of days in ICU/CCU during their admission*]

ADMISSION #1

a) Reason: ☐ Unknown ☐ Yes (specify)→ _____

b) Major Surgery/ Procedure: ☐ Unknown ☐ No ☐ Yes (specify)→ _____

c) Admit Date: ☐ Unknown [ ][ ] [ ][ ] 2 0 [ ][ ] (dd/mm/yyyy)

d) Admit to ICU/CCU: ☐ Unknown ☐ No ☐ Yes (specify)→ [ ][ ] (# of Days) ☐ Unknown

e) Discharged? ☐ No (enter ANTICIPATED d/c date) → [ ][ ] [ ][ ] 2 0 [ ][ ] (dd/mm/yyyy) ☐ Unknown

☐ Unknown ☐ Yes → (enter ACTUAL d/c date) [ ][ ] [ ][ ] 2 0 [ ][ ] (dd/mm/yyyy) ☐ Unknown

→ (enter d/c location): _____ ☐ Unknown

ADMISSION #2

a) Reason: ☐ Unknown ☐ Yes (specify)→ _____

b) Major Surgery/ Procedure: ☐ Unknown ☐ No ☐ Yes (specify)→ _____

c) Admit Date: ☐ Unknown [ ][ ] [ ][ ] 2 0 [ ][ ] (dd/mm/yyyy)

d) Admit to ICU/CCU: ☐ Unknown ☐ No ☐ Yes (specify)→ [ ][ ] (# of Days) ☐ Unknown

e) Discharged? ☐ No (enter ANTICIPATED d/c date) → [ ][ ] [ ][ ] 2 0 [ ][ ] (dd/mm/yyyy) ☐ Unknown

☐ Unknown ☐ Yes → (enter ACTUAL d/c date) [ ][ ] [ ][ ] 2 0 [ ][ ] (dd/mm/yyyy) ☐ Unknown

→ (enter d/c location): _____ ☐ Unknown

ADMISSION #3

a) Reason: ☐ Unknown ☐ Yes (specify)→ _____

b) Major Surgery/ Procedure: ☐ Unknown ☐ No ☐ Yes (specify)→ _____

c) Admit Date: ☐ Unknown [ ][ ] [ ][ ] 2 0 [ ][ ] (dd/mm/yyyy)

d) Admit to ICU/CCU: ☐ Unknown ☐ No ☐ Yes (specify)→ [ ][ ] (# of Days) ☐ Unknown

e) Discharged? ☐ No (enter ANTICIPATED d/c date) → [ ][ ] [ ][ ] 2 0 [ ][ ] (dd/mm/yyyy) ☐ Unknown

☐ Unknown ☐ Yes → (enter ACTUAL d/c date) [ ][ ] [ ][ ] 2 0 [ ][ ] (dd/mm/yyyy) ☐ Unknown

→ (enter d/c location): _____ ☐ Unknown

CYCLE RCT #142 **Plate #074** **Visit #090**

Patient ID [ ][ ] 1 [ ][ ][ ] (site #) (patient #) Coded Patient Initials [ ][ ] F L Date of Assessment [ ][ ] [ ][ ] 2 0 [ ][ ] (dd/mm/yyyy)

90 DAY FOLLOW-UP QUESTIONNAIRE (Form RC 4.5 of 13)

Part 3: Family Doctor Visits

3.1 Since your hospital discharge, have you been to see your family doctor for any reason?

☐ Unknown (go to 4.1)
☐ No (go to 4.1) ☐ Yes → How many visits? [ ][ ] (# visits) ☐ Unknown

3.2 Do you feel any of these family doctor visits were because of your initial admission to the ICU 3 months ago

☐ Unknown
☐ No ☐ Yes → How many visits? [ ][ ] (# visits) ☐ Unknown

Part 4: Specialist Visits

4.1 Since your hospital discharge, have you visited a specialist for any reason?

☐ Unknown (go to 5.1)
☐ No (go to 5.1) ☐ Yes (complete table below)

[*Interviewer: If yes, ask the patient about the type(s) of specialist(s), the number of visits to each, and how many of these visits were because of their admission to ICU*]

	Visited/ Seen			**Visits**		**Visits related to initial ICU admission**		**Reimbursed by governement and/ or insurance plan**		
Specialist	Unknown.	No	Yes	Unknown.	**(#)**	Unknown.	**(#)**	Unknown.	No	Yes
Neurologist	☐	☐	☐→	☐	[ ][ ]	☐	[ ][ ]	☐	☐	☐
Respirologist/ Pulmonologist	☐	☐	☐→	☐	[ ][ ]	☐	[ ][ ]	☐	☐	☐
Cardiologist	☐	☐	☐→	☐	[ ][ ]	☐	[ ][ ]	☐	☐	☐
Dermatologist	☐	☐	☐→	☐	[ ][ ]	☐	[ ][ ]	☐	☐	☐
Ear/Nose/Throat Specialist	☐	☐	☐→	☐	[ ][ ]	☐	[ ][ ]	☐	☐	☐
Gastroenterologist	☐	☐	☐→	☐	[ ][ ]	☐	[ ][ ]	☐	☐	☐
Physiatrist (Rehabilitation Doctor)	☐	☐	☐→	☐	[ ][ ]	☐	[ ][ ]	☐	☐	☐
Nephrologist	☐	☐	☐→	☐	[ ][ ]	☐	[ ][ ]	☐	☐	☐
Psychiatrist	☐	☐	☐→	☐	[ ][ ]	☐	[ ][ ]	☐	☐	☐
Surgeon	☐	☐	☐→	☐	[ ][ ]	☐	[ ][ ]	☐	☐	☐
Dentist	☐	☐	☐→	☐	[ ][ ]	☐	[ ][ ]	☐	☐	☐
Other: _____	☐	☐	☐→	☐	[ ][ ]	☐	[ ][ ]	☐	☐	☐
Other: _____	☐	☐	☐→	☐	[ ][ ]	☐	[ ][ ]	☐	☐	☐

CYCLE RCT #142 **Plate #075** **Visit #090**

Patient ID [ ][ ] 1 [ ][ ][ ] (site #) (patient #)

Coded Patient Initials [ ][ ] F L

Date of Assessment [ ][ ] [ ][ ] 2 0 [ ][ ] (dd/mm/yyyy)

90 DAY FOLLOW-UP QUESTIONNAIRE (Form RC 4.6 of 13)

Part 5: Other Healthcare Professionals/ Services

5.1 Since your hospital discharge, have you seen any other healthcare professionals or used any of the following services for any reason?

☐ Unknown (go to 6.1A)

☐ No (go to 6.1A) ☐ Yes (complete table below)

[*Interviewer: If yes, ask the patient about the type(s) of professional(s), the number of visits to each, and how many of these visits were because of their admission to ICU*]

Professional	**Visited/ Seen**			**Visits**		**Visits related to initial ICU admission**		**Reimbursed by governement and/ or insurance plan**		
	Unknown.	No	Yes	Unknown.	**(#)**	Unknown.	**(#)**	Unknown.	No	Yes
Nurse Practitioner	☐	☐	☐→	☐	☐☐	☐	☐☐	☐	☐	☐
Visiting Nurse (e.g. Home Care)	☐	☐	☐→	☐	☐☐	☐	☐☐	☐	☐	☐
Private Nurse	☐	☐	☐→	☐	☐☐	☐	☐☐	☐	☐	☐
Homemaker/ Personal Support Worker	☐	☐	☐→	☐	☐☐	☐	☐☐	☐	☐	☐
Physiotherapist/ Physical Therapist	☐	☐	☐→	☐	☐☐	☐	☐☐	☐	☐	☐
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: _____	☐	☐	☐→	☐	☐☐	☐	☐☐	☐	☐	☐

CYCLE RCT #142 **Plate #077** **Visit #090**

Patient ID [ ][ ] 1 [ ][ ][ ] (site #) (patient #)

Coded Patient Initials [ ][ ] F L

Date of Assessment [ ][ ] [ ][ ] 2 0 [ ][ ] (dd/mm/yyyy)

90 DAY FOLLOW-UP QUESTIONNAIRE (Form RC 4.7 of 13)

Part 6: Assistance from Others (e.g. spouse, relative, friend, other caregiver)

6.1 Since your hospital discharge, have you required assistance from others to help you with your daily activities?

☐ Unknown ☐ No → (go to 7.1)
☐ Yes

6.2 For how many weeks did you require assistance from others with your daily activities?

☐ Unknown ☐☐ (# weeks)

6.3 For how many hours on average in a typical week did you require this assistance?

☐ Unknown ☐☐ (# hours)

6.4 Was the person who was assisting you working?

☐ Unknown ☐ No → (go to 7.1)
☐ Yes

6.5 Did this person have to take time off work?

☐ Unknown ☐ No → (go to 7.1)
☐ Yes

6.6 How many days did this person have to take off from work?

☐ Unknown ☐☐ (# days)

CYCLE RCT #142 **Plate #076** **Visit #090**

Patient ID [ ][ ] 1 [ ][ ][ ] (site #) (patient #) Coded Patient Initials [ ][ ] F L Date of Assessment [ ][ ] [ ][ ] 2 0 [ ][ ] (dd/mm/yyyy)

90 DAY FOLLOW-UP QUESTIONNAIRE (Form RC 4.8 of 13)

Part 7: Employment Status and Time-off-work from Paid Employment

7.1A How many hours per week are you currently working?

☐ Unknown ☐☐ (# hours)

7.1B Before you were admitted to the ICU 3 months ago, which of the following best describes your employment status or main activity?

[*Interviewer: Read list and tick one box only*]

☐ Unknown

(1) ☐ Working at a full-time job (>35 hours/week)

(2) ☐ Working at a part-time job (<35 hours/week)

→ **If (1) or (2) go to Q7.2**

(3) ☐ Employed but on temporary sick leave or long-term disability

(4) ☐ Looking for work/between jobs

(5) ☐ Going to school

(6) ☐ Homemaking

(7) ☐ Retired

(8) ☐ Other (specify)_____

→ **If (3) to (8) Section A is complete (do not complete 7.2 to 7.4)**

7.2 If you were working full-time/part-time before your admission to the ICU, how many hours/week were you working in a typical week?

☐ Unknown ☐☐ (# hours)

7.3 Have you returned to work since your ICU admission 3 months ago?

☐ Unknown ☐ No → (Section A is complete)

☐ Yes → (go to 7.4)

7.4 What was the date of your first day back at work; number of weeks after hospital discharge patient returned to work?

☐ Unknown ☐☐ ☐☐ 2 0 ☐☐ (dd/mm/yyyy)

OR

☐☐ (# weeks)

END SECTION A

****Stop here if the patient died during hospital stay relative to the index admission****

Continue to Section B if patient is alive at the time of follow-up

CYCLE RCT #142 **Plate #078** **Visit #090**

Patient ID (site #) 1 (patient #) Coded Patient Initials F L Date of Assessment (dd/mm/yyyy) 2 0

90 DAY FOLLOW-UP QUESTIONNAIRE (Form RC 4.9 of 13)

SECTION B: PATIENT REPORTED OUTCOMES

Please complete this section if patient is alive at the time of follow-up

**Section must be completed by patient or by SDM/LAR with patient input, with the exception that "Clinical Frailty Scale" can be completed by SDM/LAR only.*

Reason # not done

1. (Intentionally omitted)
2. (Intentionally omitted)
3. (Intentionally omitted)
4. (Intentionally omitted)
5. Patient or Proxy refusal
6. Assessment missed
7. Cognitive issue - patient too sedated/agitated
8. Cognitive issue - patient unable to follow commands
9. (Intentionally omitted)
10. (Intentionally omitted)
11. Other assessment prioritized
12. Other (specify)

Part 1: Clinical Frailty Scale

[Interviewer: Ask the patient questions as necessary to discern their level of frailty based on the scale below. The following are some questions that may help clarify the patient's health status, level of activity, and functional status]

2.1 Do you need help with the following activities?

- ☐ Bathing (if so, how much help?)
- ☐ Dressing (if so, how much help?)
- ☐ Transportation
- ☐ Light housekeeping
- ☐ Heavy housework
- ☐ Finances
- ☐ Outside activities
- ☐ Taking medications
- ☐ Meal preparation

2.2 Do you experience any disease symptoms throughout your day (e.g. SOB, pain, headache, etc.)?

☐ No ☐ Yes → do these symptoms limit your activities or cause you to feel slowed up and/or tired throughout the day?

☐ No ☐ Yes

2.3 How are you managing with the stairs? _____

2.4 How often do you exercise?

☐ Regularly ☐ Seasonally or occasionally ☐ Not regularly beyond routine walking

2.4 Do you feel fitter than most people your age?

☐ No ☐ Yes

[Interviewer: *please select the highest score from the descriptions below from 1 to 9. If the patient has characteristics from higher descriptors, then please report the highest score.]*

CYCLE RCT #142 **Plate #079** **Visit #090**

Patient ID [ ][ ] 1 [ ][ ][ ] (site #) (patient #) Coded Patient Initials [ ][ ] F L Date of Assessment [ ][ ] [ ][ ] 2 0 [ ][ ] (dd/mm/yyyy)

90 DAY FOLLOW-UP QUESTIONNAIRE (Form RC 4.10 of 13)

**Section can be completed by SDM/LAR only, patient or SDM/LAR with patient input.*

Considering the patient's current status, please select the highest score from the descriptions below from 1 to 9.
If the patient has characteristics from higher descriptors, then please report the highest score.

[ ][ ] Reason # not done

(specify) _____

_____

_____

SCORE

[ ]

1. **VERY FIT**: People who are robust, active, energetic and motivated. These people commonly exercise regularly. They are among the fittest for their age.

2. **WELL**: People who have **no active disease symptoms** but are less fit than category 1. Often, they exercise or are very **active occasionally**,e.g. seasonally

3. **MANAGING WELL**: People whose **medical problems are well controlled,** but are **not regularly active** beyond routine walking.

4. **VULNERABLE**: While **not dependent** on others for daily help, often **symptoms limit activities.** A common complaint is being "slowed up",and/or being tired during the day.

5. **MILDLY FRAIL**: These people often have **more evident slowing**, and need help in **high order IADLS** (finances, transportation, heavy housework, medications). Typically, mild frailty progressively impairs shopping and walking outside alone, meal preparation and housework.

6. **MODERATELY FRAIL**: People who need help with **all outside activities** and with **keeping house**. Inside, they often have problems with stairs and need **help with bathing** and might need minimal assistance (cuing, standby) with dressing.

7. **SEVERELY FRAIL**: **Completely dependent for personal care**, from whatever cause (physical or cognitive). Even so, they seem stable and not at high risk of dying (within ~ 6 months).

8. **VERY SEVERELY FRAIL**: Completely dependent, approaching the end of life. Typically, they could not recover even from a minor illness

9. **TERMINALLY ILL**: Approaching the end of life. This category applies to people with **a life expectancy <6 months**, who are **not otherwise evidently frail.**

Scoring frailty in people with dementia: The degree of frailty corresponds to the degree of dementia.

Common **symptoms in mild dementia** include forgetting the details of a recent event, though still remembering the event itself, repeating the same question/story and social withdrawal.

In **moderate dementia**, recent memory is very impaired, even though they seemingly can remember their past life events well. They can do personal care with prompting.

In **severe dementia**, they cannot do personal care without help.

CYCLE RCT #142 **Plate #080** **Visit #090**

Patient ID [ ][ ] 1 [ ][ ][ ] (site #) (patient #) Coded Patient Initials [ ][ ] F L Date of Assessment [ ][ ] [ ][ ] 2 0 [ ][ ] (dd/mm/yyyy)

90 DAY FOLLOW-UP QUESTIONNAIRE (Form RC 4.11 of 13)

**Section must only be completed by patient or SDM/LAR with patient input.*

Part 2: EQ-5D

1. "I will read several statements pertaining to a particular topic to you and I would like you to tell me which best describe your health **today**."
"The next section of this questionnaire focuses on quality of life."

[Interviewer: Read each statement for each category and tick the corresponding box to the patient's response]

2. "We would like to know how good or bad your health is **today.** Picture a scale numbered from 0 to 100. 100 means the best health you can imagine. 0 means the worst health you can imagine. Where on this scale would you place your health **today**?"

[Interviewer: Record the number between 0-100 in the provided box]

1. EQ-5D: Descriptive System: Today's Perception

[ ][ ] Reason # not done (specify) _____

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 ☐

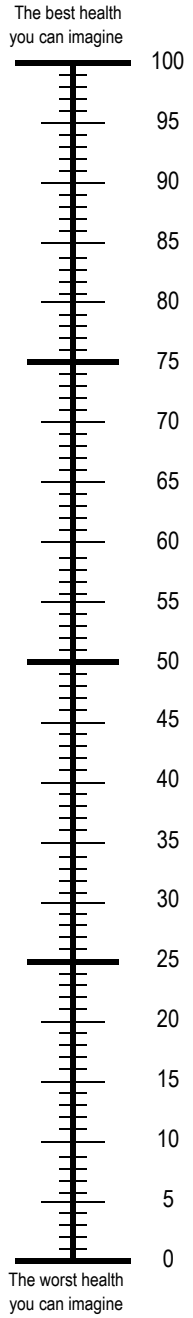
ANXIETY / DEPRESSION
- I am not anxious or depressed ☐
- I am slightly anxious or depressed ☐
- I am moderately anxious or depressed ☐
- I am severely anxious or depressed ☐
- I am extremely anxious or depressed ☐

2. EQ-5D: Visual Analogue Scale: Today's Perception

[ ][ ] Reason # not done (specify) _____

YOUR HEALTH SCORE TODAY

[ ][ ][ ]



CYCLE RCT #142 **Plate #081** **Visit #090**

Patient ID [ ][ ] 1 [ ][ ][ ] (site #) (patient #) Coded Patient Initials [ ][ ] F L Date of Assessment [ ][ ] [ ][ ] 2 0 [ ][ ] (dd/mm/yyyy)

90 DAY FOLLOW-UP QUESTIONNAIRE (Form RC 4.12 of 13)

**Section must only be completed by patient or SDM/LAR with patient input.*

Part 3: Hospital Anxiety and Depression Scale

[ ][ ] Reason # not done (specify) _____

"I will now read some statements and replies to you that relate to anxiety and depression. For each statement, please let me know which reply is the closest to how you have been feeling in the past week."

[Interviewer: Tick the box beside the patient's response for each question. See the scoring instructions below. The patient will receive a separate score for each Depression and Anxiety]

Hospital Anxiety (A) and Depression (D) Scale (HADS)

STATEMENT	D	A	0	D	A	1	D	A	2	D	A	3
1. I feel tense or "wound up":		☐	Not at all		☐	From time to time, occasionally		☐	A lot of the time		☐	Most of the time
2. I still enjoy things I used to enjoy:	☐		Definitely as much	☐		Not quite as much	☐		Only a little	☐		Hardly at all
3. I get sort of frightened feeling as if something awful is about to happen:		☐	Not at all		☐	A little, but it doesn't worry me		☐	Yes, but not too badly		☐	Yes, definitely and quite badly
4. I can laugh and see the funny side of things:	☐		As much as I always could	☐		Not quite so much now	☐		Definitely not so much now	☐		Not at all
5. Worrying thoughts go through my mind:		☐	Only occasionally		☐	From time to time, but not too often		☐	A lot of the time		☐	A great deal of the time
6. I feel cheerful:	☐		Most of the time	☐		Sometimes	☐		Not often	☐		Not at all
7. I can sit at ease and feel relaxed:		☐	Definitely		☐	Usually		☐	Not often		☐	Not at all
8. I feel as if I'm slowed down:	☐		Not at all	☐		Sometimes	☐		Very often	☐		Nearly all the time
9. I get sort of frightened feeling like "butterflies" in my stomach:		☐	Not at all		☐	Occasionally		☐	Quite often		☐	Very often
10. I have lost interest in my appearance:	☐		I take just as much care as ever	☐		I may not take quite as much care	☐		I don't take as much care as I should	☐		Definitely
11. I feel restless as I have to be on the move:		☐	Not at all		☐	Not very much		☐	Quite a lot		☐	Very much indeed
12. I look forward with enjoyment to things:	☐		As much as I ever did	☐		Rather less than I used to	☐		Definitely less than I used to	☐		Hardly at all
13. I get sudden feelings of panic:		☐	Not at all		☐	Not very often		☐	Quite often		☐	Very often indeed
14. I can enjoy a good book or radio or tv program:	☐		Often	☐		Sometimes	☐		Not often	☐		Very seldom

SCORING				SUM
DEPRESSION TOTAL:	[ ][ ] x 0 = [0][0]	[ ][ ] x 1 = [ ][ ]	[ ][ ] x 2 = [ ][ ]	[ ][ ] x 3 = [ ][ ]	[ ][ ]
ANXIETY TOTAL:	[ ][ ] x 0 = [0][0]	[ ][ ] x 1 = [ ][ ]	[ ][ ] x 2 = [ ][ ]	[ ][ ] x 3 = [ ][ ]	[ ][ ]

Scoring Instructions: Add up the number of checkmarks in each vertical column and write the total on the blank line at the bottom of that column. Multiply each column's total by the corresponding score for that column (0, 1, 2, or 3) and write this in the blank box. Add up the total of the boxes horizontally across each row to determine the separate total scores for both depression and anxiety

(0-7 = Normal ; 8-10 = Borderline Abnormal ; 11-21 = Abnormal)

CYCLE RCT #142 **Plate #082** **Visit #090**

Patient ID [ ][ ] 1 [ ][ ][ ] (site #) (patient #) Coded Patient Initials [ ][ ] F L Date of Assessment [ ][ ] [ ][ ] 2 0 [ ][ ] (dd/mm/yyyy)

90 DAY FOLLOW-UP QUESTIONNAIRE (Form RC 4.13 of 13)

**Section must only be completed by patient or SDM/LAR with patient input.*

Part 4: Patient-Reported Functional Scale - ICU

[ ][ ] Reason # not done (specify) _____

"I'm going to ask you about how well you think you can do 6 activities **today**, compared to your ability to do them before your ICU admission. Picture a scale from 0 to 10. 10 means you can do the activity as well as you could before your ICU admission. 0 means you are unable to do this activity now."

[Interviewer: Read the activities from 1-6 and record patient's score in the provided box. If the patient reports the activity is not relevant to them, please state, "If you are not doing this now, do you imagine you would have any difficulty?]

Unable to perform activity 0 1 2 3 4 5 6 7 8 9 10 **Able to perform activity at same level as before ICU admission**

ACTIVITY	SCORE
1. Rolling in bed	[ ][ ]/10
2. Moving from lying in the bed to sitting at the edge of the bed	[ ][ ]/10
3. Moving from sitting to standing	[ ][ ]/10
4. Transferring from bed to chair	[ ][ ]/10
5. Walking the length of a football field (100 m / 110 yards)	[ ][ ]/10
6. Climbing 1 flight of stairs (10 steps)	[ ][ ]/10
SUM TOTAL	[ ][ ]/60
FINAL SCORE (sum total / 6)	[ ][ ].[ ]

END SECTION B

CYCLE RCT #142 **Plate #099** **Visit #100**

Patient ID [ ][ ] 1 [ ][ ][ ] (site #) (patient #) Coded Patient Initials [ ][ ] F L

FINAL STATUS (Form 7.1 of 2)

1. Was the patient discharged from ICU alive?
   - ☐ Yes (enter date of discharge) → [ ][ ] [ ][ ] 2 0 [ ][ ] (dd/mm/yyyy)
   - ☐ No (enter date of death; go to Q3)
2. If alive, where was the patient discharged?
   - ☐ CCU / Stepdown / Surgical Stepdown
   - ☐ Ward
   - ☐ Other ICU (specify) _____
   - ☐ Home (independent)
   - ☐ Home (with home care)
   - ☐ Home (with unpaid caregiver assistance)
   - ☐ Retirement Home (independent)
   - ☐ Assisted Living Facility (mostly independent)
   - ☐ Nursing Home/Long Term Care Facility
   - ☐ Chronic Care Facility/Complex Continuing Care Skilled Nursing Facility
   - ☐ Long Term Acute Care (LTAC)
   - ☐ Inpatient Rehabilitation
   - ☐ Other Hospital (specify) _____
   - ☐ Other (specify) _____
3. What was the highest level of patient function on the day of ICU discharge?
   - ☐ Bedbound ☐ Sitting at edge of bed ☐ Standing ☐ Walking ☐ Data not available (reason) _____
4. Did the patient still require invasive mechanical ventilation at ICU discharge?
   - ☐ No ☐ Yes
5. Measured weight at ICU discharge
   - ☐ Not available [ ][ ][ ] (#) ☐ kg ☐ lbs
6. Was an ICU discharge order written (or "consult medicine for transfer")?
   - ☐ No ☐ Yes (enter date) → [ ][ ] [ ][ ] 2 0 [ ][ ] (dd/mm/yyyy)
7. Was the patient readmitted to the ICU?
   - ☐ No ☐ Yes (specify # readmissions) → [ ] (#)
8. Was the patient discharged from the hospital alive?
   - ☐ Yes (enter date of discharge) → [ ][ ] [ ][ ] 2 0 [ ][ ] (dd/mm/yyyy)
   - ☐ No (enter date of death; go to Q10)
9. If alive, where was the patient discharged?
   - ☐ Home (independent)
   - ☐ Home (with home care)
   - ☐ Home (with unpaid caregiver assistance)
   - ☐ Retirement Home (independent)
   - ☐ Assisted Living Facility (mostly independent)
   - ☐ Nursing Home/Long Term Care Facility
   - ☐ Chronic Care Facility/Complex Continuing Care Skilled Nursing Facility
   - ☐ Long Term Acute Care (LTAC)
   - ☐ Inpatient Rehabilitation
   - ☐ Other Hospital (specify) _____
   - ☐ Other (specify) _____
10. What was the highest level of patient function on the day of hospital discharge?
    - ☐ Bedbound ☐ Sitting at edge of bed ☐ Standing ☐ Walking ☐ Data not available (reason) _____
11. Measured weight at hospital discharge
    - ☐ Not available [ ][ ][ ] (#) ☐ kg ☐ lbs
12. Was the patient declared ALC (alternate level of care)/attente de transfer or acute care services no longer required?
    - ☐ Yes (enter date) → [ ][ ] [ ][ ] 2 0 [ ][ ] (dd/mm/yyyy)
    - ☐ No
13. Was the patient alive at 90 days post-randomization?
    - ☐ Unknown
    - ☐ Yes (enter date of 90 days post-randomization) → [ ][ ] [ ][ ] 2 0 [ ][ ] (dd/mm/yyyy)
    - ☐ No (enter date of death)

CYCLE RCT #142 **Plate #100** **Visit #100**

Patient ID [ ][ ] 1 [ ][ ][ ] (site #) (patient #) Coded Patient Initials [ ][ ] F L

FINAL STATUS (Form 7.2 of 2)

14. Was this patient co-enrolled in another study?

☐ No ☐ Yes (complete table)

Study Name	Design: RCT	Design: Observational	Funding: Academic	Funding: Industry	Funding: Local	Methods Centre Internal Study Code
1. _____	☐	☐	☐	☐	☐	☐☐☐
2. _____	☐	☐	☐	☐	☐	☐☐☐
3. _____	☐	☐	☐	☐	☐	☐☐☐
4. _____	☐	☐	☐	☐	☐	☐☐☐

15. Strength and Function assessment form completion status

Column A **Strength & Function Assessment Forms**	**Column B** Any part of ax completed/ any clinical data recorded **"Yes"** = complete "Column C" **"No"** = only "reason # not done" section(s) on Ax form complete (i.e. no clinical data recorded)	**Column C** Clinical data should apply to the following timepoints (check all) **ICU Awakening**	**ICU Discharge**	**3 D Post-ICU Discharge**	**Hospital Discharge**
ICU Awakening (SF1)	☐ Yes ☐ No	☐	☐	☐	☐
ICU Discharge (SF2)	☐ Yes ☐ No	☐	☐	☐	☐
3 Days Post-ICU Discharge (SF3)	☐ Yes ☐ No	☐	☐	☐	☐
Hospital Discharge (SF4)	☐ Yes ☐ No	☐	☐	☐	☐

16. Research Coordinator assessment form completion status

Column A **Research Coordinator Assessment Forms**	**Column B** Any part of ax completed/ any clinical data recorded **"Yes"** = complete "Column C" *(if applicable)* **"No"** = only "reason # not done" section(s) on Ax form complete (i.e. no clinical data recorded)	**Column C** Clinical data should apply to the following timepoints (check all) **ICU Awakening**	**ICU Discharge**	**3 D Post-ICU Discharge**	**Hospital Discharge**
IPAT (RC1)	☐ Yes ☐ No				
RC ICU Discharge (RC2)	☐ Yes ☐ No		☐		☐
RC Hospital Discharge (RC3)	☐ Yes ☐ No		☐		☐
90 Day Follow-up Questionnaire (RC4)	☐ Yes ☐ No				