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 ☐

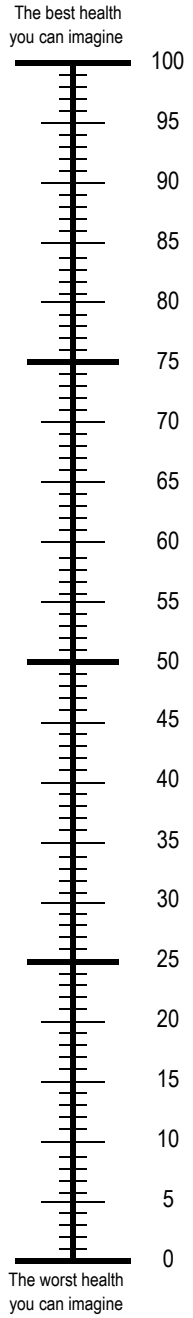
ANXIETY / DEPRESSION
- I am not anxious or depressed ☐
- I am slightly anxious or depressed ☐
- I am moderately anxious or depressed ☐
- I am severely anxious or depressed ☐
- I am extremely anxious or depressed ☐

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