

## CAHE Post-Discharge Carer Questionnaire

### Section 1: Questions about you

1. Home post code: \_\_\_\_\_

2. Today's Date: \_\_\_\_\_ / \_\_\_\_\_ / 20\_\_\_\_\_

3. Your gender: Male / Female

4. Your date of birth: \_\_\_\_\_ / \_\_\_\_\_ / 19\_\_\_\_\_

5. Your relationship to the patient? :

\_\_\_\_\_

6. **You** have been identified as the principal relative or friend who is looking after the patient in some way. Are there any other relatives or friends who also assist?

Please tick:                      **Yes**                                            **No**                     

7. Do you live at the same address as the patient?

Please tick:                      **Yes**                                            **No**                     

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*We are interested in how much information you received FROM THE hospital to prepare you for coping at home with the patient*

**Section 2: While the patient was in hospital:**

- |  |  |
|--|--|
| <p><b>1</b> How much information did <b>you</b> receive about what medications were to be taken home by the patient?</p>   | <p>As much as I needed <input type="radio"/></p> <p>Some, but not enough <input type="radio"/></p> <p>None <input type="radio"/></p> |
| <p><i>Please tick only one box</i></p>   | <p>Patent is not taking any medications</p>  |
| <p><b>2</b> How much information did you receive about the side effects of the medications to be taken home by the patient?</p>  | <p>As much as I needed <input type="radio"/></p> <p>Some, but not enough <input type="radio"/></p> <p>None <input type="radio"/></p> |
| <p><i>Please tick only one box</i></p>   | <p>Patent is not taking any medications</p>  |
| <p><b>3</b> How much information did you receive on how you would manage the patient with personal care? (i.e. how you would help the patient with showering, bathing, dressing etc)</p> | <p>As much as I needed <input type="radio"/></p> <p>Some, but not enough <input type="radio"/></p> <p>None <input type="radio"/></p> |
| <p><i>Please tick only one box</i></p>   |  |
| <p><b>4</b> How much information did you receive about community services the patient might use at home? (E.g. Domiciliary Care, District Nurse, Meals on Wheels etc)</p>                | <p>As much as I needed <input type="radio"/></p> <p>Some, but not enough <input type="radio"/></p> <p>None <input type="radio"/></p> |
| <p><i>Please tick only one box</i></p>   | <p>Patent does not need any <input type="radio"/></p>  |
| <p><b>5</b> How much information did you receive on any equipment the patient might use at home? (E.g. rails, shower chair, walking aids etc)</p>  | <p>As much as I needed <input type="radio"/></p> <p>Some, but not enough <input type="radio"/></p> <p>None <input type="radio"/></p> |
| <p><i>Please tick only one box</i></p>   | <p>Patent does not need any <input type="radio"/></p>  |
| <p><b>6</b> Comments: Would you like to add anything to your answers on this page</p>  |  |

**Section 3: Before the patient was discharged from hospital:**

- 1** Did anyone arrange community services for the patient ? (e.g. Domiciliary Care, District Nurse, Meals on Wheels etc) Please tick only one box
- |  |                       |
|--|-----------------------|
| Yes  | <input type="radio"/> |
| No   | <input type="radio"/> |
| No-one needed to:-<br>Services were already in place | <input type="radio"/> |
| No-one needed to:<br>No services needed              | <input type="radio"/> |

- .....
- If you answered **YES**, have the services commenced? **or** If you answered **SERVICES WERE ALREADY IN PLACE**, have the services recommenced?
- |     |                       |
|-----|-----------------------|
| Yes | <input type="radio"/> |
| No  | <input type="radio"/> |

- 
- 2.** Did anyone arrange equipment for the patient?  
Please tick only one box
- |  |                       |
|--|-----------------------|
| Yes  | <input type="radio"/> |
| No   | <input type="radio"/> |
| No-one needed to:-<br>Equipment already in place | <input type="radio"/> |
| No-one needed to:<br>No equipment needed         | <input type="radio"/> |

- .....
- If **YES**, does the patient have this equipment now?
- |     |                       |
|-----|-----------------------|
| Yes | <input type="radio"/> |
| No  | <input type="radio"/> |

- 
- 3.** Did anyone talk to **you** about how **you** would manage **your** usual duties while caring for the patient? (e.g. shopping, showering, bathing, dressing, toileting, feeding, mobility, transportation)  
Please tick correct box
- |     |                       |
|-----|-----------------------|
| Yes | <input type="radio"/> |
| No  | <input type="radio"/> |

- 
- 4.** Did you receive advice about services available for carers themselves? (eg carer respite services)
- |     |                       |
|-----|-----------------------|
| Yes | <input type="radio"/> |
| No  | <input type="radio"/> |
- Please tick one box only*

Please tell us more about this

- 
- 5** Comments: Would you like to add anything to your answers on this page

**Section IV: After the patient was told he/she could leave hospital:**

- 1** How confident did **you** feel about managing at home?  
*Please tick only one box*
- |               |                       |
|---------------|-----------------------|
| Confident     | <input type="radio"/> |
| Unsure        | <input type="radio"/> |
| Not confident | <input type="radio"/> |

**1a.** Please tell us more about this

.....

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.....

.....

- 2** Were there any delays in the patient leaving hospital?  
*Please tick*
- |     |                       |
|-----|-----------------------|
| Yes | <input type="radio"/> |
| No  | <input type="radio"/> |

- 2a.** If **YES**, what were the delays?  
*Please tick as many as you wish*
- |             |                       |
|-------------|-----------------------|
| Transport   | <input type="radio"/> |
| Medications | <input type="radio"/> |
| Don't know  | <input type="radio"/> |
| Other       | <input type="radio"/> |

*Please indicate* -----

**3.** Comments: Would you like to add anything to your answers on this section?

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**Section V: Now the patient has been out of hospital for a while:**

- 1** Do **you** have any health problems which make it harder for **you** to look after the patient?  
*Please tick*
- |     |                       |
|-----|-----------------------|
| Yes | <input type="radio"/> |
| No  | <input type="radio"/> |

**1a.** Please tell us more about this

.....

.....

- 2** Has anything been worrying **you** about managing the patient at home?  
*Please tick*
- |     |                       |
|-----|-----------------------|
| Yes | <input type="radio"/> |
| No  | <input type="radio"/> |

**2a.** Please tell us more about this

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**3** Has anything been done to deal with your worries? Yes   
*Please tick* No

**3a.** Please tell us more about this

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**4.** Have any unexpected problems occurred since the patient left hospital to make **you** feel less confident about managing? Yes   
*Please tick* No

**4a.** Please tell us more about this

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**5.** If the patient has already received community services, have these services met everyone's needs? Yes   
*Please tick* No

*Everyone = you, the patient and any one else involved*

**5a.** Please tell us more about this

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**6.** If equipment was provided for the patient, did it make things easier for **you**? Yes   
*Please tick* No

**6a.** Please tell us more about this

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**Section VI: in the first week after the patient left hospital**

**1** Did **you** health suffer so that **you** had to see any of the following people **more often** than usual?

*(Please put the number of times on each line)*

Your local doctor	Your specialist doctor
Physiotherapist	Chemist
Occupational Therapist	Meals on Wheels
Domiciliary Care	Other health professionals
District Nurse	Any other people who have helped you
Hospital outpatient/ Emergency clinic	<i>Please write who they were on the line below</i>
	.....

**2** Have **you** had to spend any extra money as a result of the patient's visit to hospital? *(such as taxi fares, petrol, etc)* Yes   
*Please tick* No

**2a.** If so, what are these costs approximately?

Taxi fares	\$	Petrol	\$
Extra shopping	\$	Gap payments for health services	\$
Extra chemist costs	\$	Private Health Services	\$
Other		<i>Please write who they were on the line below</i>	
		.....	

**3.** Have **you** had to use any extra electricity as a result of looking after the patient? Yes   
*Please tick* No

**3a.** If **YES**, what have you used it for?

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Section VII: Looking back to the time the patient left hospital

- 1 Overall, how prepared did you feel for caring for the patient at home?  
*Please tick*
  - Totally prepared
  - Could have been better prepared
  - Unprepared

2. Were there any particular aspects of the patient’s preparation for discharge whilst in hospital, that **you** would like to further comment on?

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3. Were there any particular aspects of the patient’s care after leaving hospital, that you would like to comment further on?

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There is also space for you to write on the back of this page if you want to write more

Thank you for taking the time to complete this questionnaire.

Please put it in an envelope and deliver to:

Name: \_\_\_\_\_

Office/Delivery: \_\_\_\_\_

(Office use: for completed forms please enter the name of the nominated person and their address/office above)