Centre for Allied Health Evidence

CAHE Post-Discharge Patient Questionnaire

Section 1: Questions about you, the patient

1. Name of Hospital Ward from which you were discharged:

   ____

2. Home post code: ______________

3. Today's Date: ___/____/ 20____

4. Your gender: Male / Female

5. Your date of birth: ___/____/ 19____

6. What was the reason for your last admission to hospital? :

   ____

7. **What date and day of the week were you discharged from hospital? :**

   ____

8. What time of the day were you discharged from hospital (include am or pm)? : ____

   ____

CONTACTS
www.unisa.edu.au/cahe
karen.grimmer-somers
@unisa.edu.au
Telephone (08) 8302 2769
Facsimile (08) 8302 2766

University of South Australia
GPO Box 2471
Adelaide SA 5001
Australia

CRICOS Provider Number
001218

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Instrument Authors
Dr Karen Grimmer
Centre for Allied Health Evidence
University of South Australia
Telephone: (08) 8302 2769
Email: Karen.Grimmer@unisa.edu.au

John Moss
Department of Public Health
University of Adelaide (operating through Adelaide Research & Innovation)
Telephone: (08) 8303 4620
Email: john.moss@adelaide.edu.au

We are interested in how much information you received in hospital to prepare you for coping at home

Section 2: While you were in hospital:

No.	Question	Response	
1	How much information did you receive about the medications that you were to take home?	As much as I needed	O
	Please tick only one box	Some, but not enough	O
		None	O
		Not taking **any** medications	O
2	How much information did you receive about the side effects of the medications that you were to take at home?	As much as I needed	O
	Please tick only one box	Some, but not enough	O
		None	O
		Not taking **any** medications	O
3	Were you given **written** instructions about your medications?	Yes	O
	Please tick only one box	No	O
		Not taking **any** medications	O
4	If **YES** did someone spend time explaining the written instructions?	Yes	O
	Please tick only one box	No	O
5	How much information did you receive on how you would **manage your usual activities** when you went home? (e.g. shopping, showering, bathing etc)	As much as I needed	O
	Please tick only one box	Some, but not enough	O
		None	O
6	How much information did you receive on **community services** you might use once you went home?	As much as I needed	O
	(e.g. Domicilary Care, District Nurse, Meals on Wheels etc)	Some, but not enough	O
	Please tick only one box	None	O
		No services needed	O
7	How much information did you receive on **equipment** you might need once you went home? (e.g. rails, shower chair, walking aids etc)	As much as I needed	O
	Please tick only one box	Some, but not enough	O
		None	O
		No equipment needed	O

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Section 3: Before you were discharged from hospital:

1 Did anyone arrange community services for you to use at home? (*e.g. Domiciliary Care, District Nurse, Meals on Wheels etc)*
Please tick only one box

- Yes O
- No O
- No-one needed to:- Services were already in place O
- No-one needed to: No services needed O

1a. If you answered **YES**, have the services commenced? ***or*** If you answered **SERVICES WERE ALREADY IN PLACE**, have the services recommenced?

- Yes O
- No O

1b. If **NO**, why? ....

....

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2. Did anyone arrange equipment for you?
Please tick only one box

- Yes O
- No O
- No-one needed to:- Equipment already in place O
- No-one needed to: No equipment needed O

2a. If **YES**, do you have this equipment now?

- Yes O
- No O

2b. If **NO**, why? ....

....

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3. Was there any other information you would have liked while you were in hospital, to prepare you for coping at home?
Please tick only one box

- Yes O
- No O

3a. Please tell us more about this

....

....

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 O
- Unsure O
- Not confident O

Please tell us more about this

……

……

2 Were there any delays on the day you left hospital?
Please tick

- Yes O
- No O

3. If **YES,** what were the delays?
Please tick as many as you wish

- Transport O
- Medications O
- Don't know O
- Other O

Please indicate ___________________________

Section V: Now you have been out of hospital for a while:

1 Has anything been worrying you about managing at home?
Please tick

- Yes O
- No O

1a. Please tell us more about this

……

……

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2 Has anything been done to deal with your worries?
Please tick

- Yes O
- No O

2a.	Please tell us more about this …………………………………………………………………………………………………… ……………………………………………………………………………………………………		
3	Are you a carer for someone else? For whom? (Spouse, child, other relative, friend, other) *Please circle*	Yes No	O O
4.	Have any unexpected problems occurred since you have been home? *Please tick*	Yes No	O O
4a.	Please tell us more about this …………………………………………………………………………………………………… ……………………………………………………………………………………………………		
5.	If the you have already received community services, have these services met your needs?… *Please tick* *Everyone = you, the patient and any one else involved*	Yes No	O O
5a.	Please tell us more about this …………………………………………………………………………………………………… ……………………………………………………………………………………………………		
6.	If equipment was provided for the patient, did it make things easier for **<u>you</u>**? *Please tick*	Yes No	O O
6a.	Please tell us more about this …………………………………………………………………………………………………… ……………………………………………………………………………………………………		

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Section VI: in the first week after you left hospital

1 How many times did you see

*(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

Please write who they were on the line below

…………………………………………………………………

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2 Did you receive any of the following services?

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

Home modifications O

Assistance with shopping O

House cleaning O

Other (Please indicate): O

………………………………………………

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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)*
Please tick

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

Taxi fares $

Petrol $

Extra shopping $

Gap payments for health services $

Extra chemist costs $

Private Health Services $

Please write who they were on the line below

Other

…………………………………………………………………

---

3. Have **you** had to use any extra electricity as a result of looking after the patient?
Please tick

Yes O

No O

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

1 Overall, how prepared did you feel for returning to home?
Please tick

Totally prepared	O
Moderately prepared	O
Unprepared	O

2. Were there any particular aspects of your preparation for discharge <u>whilst in hospital</u>, that you would like to further comment on?

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3. Were there any particular aspects of the patient's care <u>after leaving hospital</u> 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

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Section VIII: This sheet will be removed and used as a consent form for us to contact your doctor

1 When you were in hospital, what were you told to tell your usual doctor (GP) when you saw him/her?

………

……

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2 Who is your usual doctor (GP) and what is his/her address?

………

……

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3 Do you usually see any other doctors (GP's)

Please tick

Yes O
No O

If **YES**, *How many ----------------*

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4 Do you consent to us contacting your usual GP about his/her views about your recent discharge from hospital?

Please tick

Yes O
No O

If **YES**, please print your name and sign

PRINT YOUR NAME ……………………………………………………………………… DATE: ……………………………..

SIGNATURE ………………………………………………………………………

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)