# HEALTHCARE SERVICE UTILISATION FORM

**Date:** ☐☐ ☐☐ ☐☐ **Assessment Number:** ☐☐

**Question 1.**

**What drugs are prescribed for the patient?**

Please list all drugs that the patient has been prescribed in the last 4 months and the quantity that they were prescribed.

| No. | Drug | Dose | Quantity (Number of tablets) |
|---|---|---|---|
| 1 | | | |
| 2 | | | |
| 3 | | | |
| 4 | | | |
| 5 | | | |
| 6 | | | |
| 7 | | | |
| 8 | | | |
| 9 | | | |
| 10 | | | |

**Question 2.**

**In the last 4 months has the patient had a referral to any of the following?**

| Provider | | Number of Visits |
|---|---|---|
| Physiotherapy | | |
| Occupational therapy | | |
| Chiropody | | |
| Other, Please State | | |

Trial Number: ☐ ☐ ☐ ☐ ☐

**Question 3.**

**In the past 4 months has the patient had any of the following laboratory tests.**

| Type of Test | Number of tests | Where Taken (GP surgery, home hospital) |
|---|---|---|
| Blood tests | | |
| Urine tests | | |

**Question 4.**

**In the past 4 months has the patient made any visits to the hospital outpatient rheumatology department?**

| Day | Month | Year | Scheduled | | Initiated by GP | | Initiated by patient | |
|---|---|---|---|---|---|---|---|---|
| | | | Yes | No | Yes | No | Yes | No |
| □□ | /□□/ | □□□□ | □ | □ | □ | □ | □ | □ |
| □□ | /□□/ | □□□□ | □ | □ | □ | □ | □ | □ |
| □□ | /□□/ | □□□□ | □ | □ | □ | □ | □ | □ |
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**Question 5.**

**Has the patient made any other outpatient visits to any other hospital department in the last 4 months?**

| No. | Hospital | Date | Department |
|---|---|---|---|
| 1 | | | |
| 2 | | | |
| 3 | | | |
| 4 | | | |
| 5 | | | |
| 6 | | | |
| 7 | | | |
| 8 | | | |

**Question 6.**

**Has the patient been admitted by the rheumatology department for an in-patient stay in the last 4 months?**

| No. | Date Admitted | Date Discharged | In-patient days. |
|---|---|---|---|
| 1 | | | |
| 2 | | | |
| 3 | | | |
| 4 | | | |
| 5 | | | |

**Question 7.**

**Has the patient been admitted for an in-patient stay for orthopaedic surgery in the last 4 months?**

| No. | Date Admitted | Date Discharged | In-patient days. |
|---|---|---|---|
| 1 | | | |
| 2 | | | |
| 3 | | | |
| 4 | | | |
| 5 | | | |

**Question 8.**

**Has the patient had any in-patient stays in the last 4 months apart from those included in question six and question seven?**

| No. | Date Admitted | Date Discharged | Hospital | Department | In-Patient Days |
|---|---|---|---|---|---|
| 1 | | | | | |
| 2 | | | | | |
| 3 | | | | | |
| 4 | | | | | |
| 5 | | | | | |

**Services to aid day to day living.**

**Question 9.**

**Has the patient had any appliances, aids or house modifications in the last 12 months?**

| No | Type | Y/N | Date | Quantity | Cost to patient |
|---|---|---|---|---|---|
| 1 | Special Shoes | | | | |
| 2 | Special Clothing | | | | |
| 3 | Mobility Aids | | | | |
| 4 | Special Chair | | | | |
| 5 | Special Crockery | | | | |
| 6 | Special Cutlery | | | | |
| 7 | Special utensils | | | | |
| 8 | Tap-Turner | | | | |
| 9 | Special Door Handles | | | | |
| 10 | Dressing Aids | | | | |
| 11 | Hand Splints | | | | |
| 12 | Walking Stick | | | | |
| 13 | Raised Toilet Seat. | | | | |
| 14 | Bath Rails | | | | |
| 15 | Adaptations to pens/utensils | | | | |
| 16 | Kitchen adaptation | | | | |
| Other 1 | | | | | |
| Other 2 | | | | | |
| Other 3 | | | | | |
| Other 3 | | | | | |
| Other 5 | | | | | |

**Question 10.**

Does the patient have anybody who comes to their home to help with housework or other domestic chores?

YES/NO

If yes, how many hours a week do they spend in the patients home?_____