ELEVATE Resource Data Collection Sheet

To be filled by Patient

Date: ___/___/___	Visit no:	Study ID No.	Patient initials:

N☒.

Since your last visit for this study** *that date was* ____/____/____ **due to asthma, breathing difficulties, chest infections or allergic reactions of nose and/or eyes:**

1. Have you been to hospital? (Admission, A&E or Outpatient) *(if you need more space for any response please add extra sheet(s) of paper)*

Date	What was (were) the reason(s)?	A&E	Out-patient	Admitted?		For this visit (& recovery period), did you take time off work? (days/hours)		Anyone take time off work to transport or care for you			How go to hospital? By bus, taxi, Ambulance, paid carer, friend, your car?
				yes	No. nights			How much?		Their job?	
		☐	☐	☐		days	hours	days	Hours		
		☐	☐	☐		days	hours	days	Hours		
		☐	☐	☐		days	hours	days	Hours		
		☐	☐	☐		days	hours	days	Hours		

2. Have you been to see, or called, any GP, nurse, on call service, or other health professional or alternative practitioner?

For example: physiotherapist, homeopath, psychologist, acupuncturist, emergency cover GP

Date	What was (were) the reason(s)?	Who did you see or talk to?	How seen?		Where? (home, surgery, clinic, A&E or other)	When?			For you: time off work?		Anyone take time off work to transport or care for you		
			in person	phone		surgery hrs,	6-10PM,	10PM-8AM			time off work?		Their job?
			☐	☐		☐	☐	☐	days	hours	days	hours	
			☐	☐		☐	☐	☐	days	hours	days	hours	
			☐	☐		☐	☐	☐	days	hours	days	hours	
			☐	☐		☐	☐	☐	days	hours	days	hours	
			☐	☐		☐	☐	☐	days	hours	days	hours	
			☐	☐		☐	☐	☐	days	hours	days	hours	
			☐	☐		☐	☐	☐	days	hours	days	hours	
			☐	☐		☐	☐	☐	days	hours	days	hours	

** "last visit" refers to the previous scheduled visit to your GP for the ELEVATE Study. The 7 scheduled study visits are at 0, 2, 10, 26, 52, 78 & 104 weeks.

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Since your last visit, due to asthma, breathing difficulties, chest infections or allergic reactions of nose and/or eyes:

3. Have you bought anything from pharmacy, or some other source, to help you with your health?

For example: antihistamines, analgesics, nicotine patches, peak flow meter, cleaning devices, special bedding, air conditioner, humidifier, nebuliser, ioniser

NB for regular asthma prescription items (eg. inhalers, tablets) please give your best estimate of the date and the number of items purchased.

Date	What did you purchase?	Cost	Why purchase

4. *Have there been* ***any other occasions*** *when your asthma has been worse –eg. when you had to take time off work?*

Date	Did you treat yourself?	What did you do, or use, in self-treating?	Did you take time off work?	Number hrs or days off (specify days or hrs)		Anyone take time off for you?			Any other costs? comments?
						time off work?		Their job?	
				days	hours	days	hours		
				days	hours	days	hours		
				days	hours	days	hours		
				days	hours	days	hours		
				days	hours	days	hours		

Please collect the resource diary from the patient and post it to the study office along with this and the other forms.

ELEVATE medication follow up.

Patient initials: DM	Date: ___/___/___	Visit no: 6	Study ID No. 110157

If any questions about filling this form – feel free to write out a brief description on the reverse.

All Medications

Asthma, other respiratory problems or respiratory tract infections and other health issues.

DRUG NAME	ROUTE	TOTAL DAILY DOSAGE Dose	Units	START DATE (DD Mon-YYYY)	STOP DATE (DD Mon-YYYY)	**WHY?** If new: name of medical condition being treated – If dosage change: reason	Adverse Event?
				___/___/___	___/___/___		If Yes ☐
				___/___/___	___/___/___		If Yes ☐
				___/___/___	___/___/___		If Yes ☐
				___/___/___	___/___/___		If Yes ☐
				___/___/___	___/___/___		If Yes ☐
				___/___/___	___/___/___		If Yes ☐
				___/___/___	___/___/___		If Yes ☐
				___/___/___	___/___/___		If Yes ☐
				___/___/___	___/___/___		If Yes ☐
				___/___/___	___/___/___		If Yes ☐
				___/___/___	___/___/___		If Yes ☐
				___/___/___	___/___/___		If Yes ☐
				___/___/___	___/___/___		If Yes ☐
				___/___/___	___/___/___		If Yes ☐
				___/___/___	___/___/___		If Yes ☐

Drug Name: use generic name except: use trade name for fixed combinations only, and use trade name for medications with multiple active ingredients. **Route**: PO (oral), IV (intravenous infusion), IM (intramuscular), INH (inhalant), Other.

- Please list **ALL** medications taken since last study visit.
- Repeat prescriptions should only be listed one time.
- Dose – total mg or mcg for the entire day – for a drug taken on an "as needed" basis, write "as needed"
- Start date: if medication has been taken long term, but dosage changed, use date when current specific dosage started. NB: **Dates can be approximate -don't have to be precise.**

If total daily dose changes, make an additional entry.

- Stop date: Only specify this date if drug is discontinued or dosage is changed. Date can be approximate.
- Why: Give medical indication for discontinuation or dosage change
- Adverse Event? Only tick yes box if an adverse event occurs.