



Hip replacement Participant Resource Use Log: 0 to 3 months



Thank you for agreeing to take part in the APEX study. After you have been in the study for three months you will be sent a questionnaire. In this questionnaire we will ask you some questions about the services you have used and anything you have had to buy because of your recent **hip** replacement. We are doing this to find out whether the type of anaesthetic you had during surgery alters the cost of treatment.

We know that it can be difficult to remember all the events that may occur over the next 3 months. This form is designed for you to record these events. Please do not include details of any visits to Southmead Hospital as we have this information and please only include events relating to your **hip** replacement. Using this form will help you complete the questionnaire you will be sent three months after your operation.

Please record here all **non** Southmead Hospital (SMH) NHS services you have used since your initial discharge from the Avon Orthopaedic Centre (AOC) for reasons relating to your hip replacement.

Tick the relevant boxes to keep count of how many times you use each service.

I had an appointment with the GP at the GP practice					
Visit 01 <input type="checkbox"/>	Visit 02 <input type="checkbox"/>	Visit 03 <input type="checkbox"/>	Visit 04 <input type="checkbox"/>	Visit 05 <input type="checkbox"/>	Visit 06 <input type="checkbox"/>
Visit 07 <input type="checkbox"/>	Visit 08 <input type="checkbox"/>	Visit 09 <input type="checkbox"/>	Visit 10 <input type="checkbox"/>	Visit 11 <input type="checkbox"/>	Visit 12 <input type="checkbox"/>
Visit 13 <input type="checkbox"/>	Visit 14 <input type="checkbox"/>	Visit 15 <input type="checkbox"/>	Visit 16 <input type="checkbox"/>	Visit 17 <input type="checkbox"/>	Visit 18 <input type="checkbox"/>
I had a GP visit me at home					
Visit 01 <input type="checkbox"/>	Visit 02 <input type="checkbox"/>	Visit 03 <input type="checkbox"/>	Visit 04 <input type="checkbox"/>	Visit 05 <input type="checkbox"/>	Visit 06 <input type="checkbox"/>
Visit 07 <input type="checkbox"/>	Visit 08 <input type="checkbox"/>	Visit 09 <input type="checkbox"/>	Visit 10 <input type="checkbox"/>	Visit 11 <input type="checkbox"/>	Visit 12 <input type="checkbox"/>
Visit 13 <input type="checkbox"/>	Visit 14 <input type="checkbox"/>	Visit 15 <input type="checkbox"/>	Visit 16 <input type="checkbox"/>	Visit 17 <input type="checkbox"/>	Visit 18 <input type="checkbox"/>
I phoned the GP for advice					
Call 01 <input type="checkbox"/>	Call 02 <input type="checkbox"/>	Call 03 <input type="checkbox"/>	Call 04 <input type="checkbox"/>	Call 05 <input type="checkbox"/>	Call 06 <input type="checkbox"/>
Call 07 <input type="checkbox"/>	Call 08 <input type="checkbox"/>	Call 09 <input type="checkbox"/>	Call 10 <input type="checkbox"/>	Call 11 <input type="checkbox"/>	Call 12 <input type="checkbox"/>
I visited the GP practice nurse at the GP practice					
Visit 01 <input type="checkbox"/>	Visit 02 <input type="checkbox"/>	Visit 03 <input type="checkbox"/>	Visit 04 <input type="checkbox"/>	Visit 05 <input type="checkbox"/>	Visit 06 <input type="checkbox"/>
Visit 07 <input type="checkbox"/>	Visit 08 <input type="checkbox"/>	Visit 09 <input type="checkbox"/>	Visit 10 <input type="checkbox"/>	Visit 11 <input type="checkbox"/>	Visit 12 <input type="checkbox"/>
Visit 13 <input type="checkbox"/>	Visit 14 <input type="checkbox"/>	Visit 15 <input type="checkbox"/>	Visit 16 <input type="checkbox"/>	Visit 17 <input type="checkbox"/>	Visit 18 <input type="checkbox"/>
I phoned the GP Practice Nurse for advice					
Call 01 <input type="checkbox"/>	Call 02 <input type="checkbox"/>	Call 03 <input type="checkbox"/>	Call 04 <input type="checkbox"/>	Call 05 <input type="checkbox"/>	Call 06 <input type="checkbox"/>
Call 07 <input type="checkbox"/>	Call 08 <input type="checkbox"/>	Call 09 <input type="checkbox"/>	Call 10 <input type="checkbox"/>	Call 11 <input type="checkbox"/>	Call 12 <input type="checkbox"/>
I got a repeat prescription (without seeing the doctor)					
Prescription 1 <input type="checkbox"/>	Prescription 2 <input type="checkbox"/>	Prescription 3 <input type="checkbox"/>	Prescription 4 <input type="checkbox"/>	Prescription 5 <input type="checkbox"/>	

A District nurse visited me at home

Visit 01 <input type="checkbox"/>	Visit 02 <input type="checkbox"/>	Visit 03 <input type="checkbox"/>	Visit 04 <input type="checkbox"/>	Visit 05 <input type="checkbox"/>	Visit 06 <input type="checkbox"/>
Visit 07 <input type="checkbox"/>	Visit 08 <input type="checkbox"/>	Visit 09 <input type="checkbox"/>	Visit 10 <input type="checkbox"/>	Visit 11 <input type="checkbox"/>	Visit 12 <input type="checkbox"/>
Visit 13 <input type="checkbox"/>	Visit 14 <input type="checkbox"/>	Visit 15 <input type="checkbox"/>	Visit 16 <input type="checkbox"/>	Visit 17 <input type="checkbox"/>	Visit 18 <input type="checkbox"/>
Visit 19 <input type="checkbox"/>	Visit 20 <input type="checkbox"/>	Visit 21 <input type="checkbox"/>	Visit 22 <input type="checkbox"/>	Visit 23 <input type="checkbox"/>	Visit 24 <input type="checkbox"/>

An Occupational therapist visited me at home

Visit 01 <input type="checkbox"/>	Visit 02 <input type="checkbox"/>	Visit 03 <input type="checkbox"/>	Visit 04 <input type="checkbox"/>	Visit 05 <input type="checkbox"/>	Visit 06 <input type="checkbox"/>

I visited an Occupational therapist at GP surgery/non SMH clinic visit

Visit 01 <input type="checkbox"/>	Visit 02 <input type="checkbox"/>	Visit 03 <input type="checkbox"/>	Visit 04 <input type="checkbox"/>	Visit 05 <input type="checkbox"/>	Visit 06 <input type="checkbox"/>

A Community Physiotherapist visited me at home

Visit 01 <input type="checkbox"/>	Visit 02 <input type="checkbox"/>	Visit 03 <input type="checkbox"/>	Visit 04 <input type="checkbox"/>	Visit 05 <input type="checkbox"/>	Visit 06 <input type="checkbox"/>
Visit 07 <input type="checkbox"/>	Visit 08 <input type="checkbox"/>	Visit 09 <input type="checkbox"/>	Visit 10 <input type="checkbox"/>	Visit 11 <input type="checkbox"/>	Visit 12 <input type="checkbox"/>
Visit 13 <input type="checkbox"/>	Visit 14 <input type="checkbox"/>	Visit 15 <input type="checkbox"/>	Visit 16 <input type="checkbox"/>	Visit 17 <input type="checkbox"/>	Visit 18 <input type="checkbox"/>
Visit 19 <input type="checkbox"/>	Visit 20 <input type="checkbox"/>	Visit 21 <input type="checkbox"/>	Visit 22 <input type="checkbox"/>	Visit 23 <input type="checkbox"/>	Visit 24 <input type="checkbox"/>

I visited a Community Physiotherapist at the GP surgery/non SMH clinic

Visit 01 <input type="checkbox"/>	Visit 02 <input type="checkbox"/>	Visit 03 <input type="checkbox"/>	Visit 04 <input type="checkbox"/>	Visit 05 <input type="checkbox"/>	Visit 06 <input type="checkbox"/>
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Use of Other Non SMH services which are provided by the NHS

Please specify type of service and record each time you visit

Visit 01 <input type="checkbox"/>	Visit 02 <input type="checkbox"/>	Visit 03 <input type="checkbox"/>	Visit 04 <input type="checkbox"/>	Visit 05 <input type="checkbox"/>	Visit 06 <input type="checkbox"/>
Visit 07 <input type="checkbox"/>	Visit 08 <input type="checkbox"/>	Visit 09 <input type="checkbox"/>	Visit 10 <input type="checkbox"/>	Visit 11 <input type="checkbox"/>	Visit 12 <input type="checkbox"/>
Visit 13 <input type="checkbox"/>	Visit 14 <input type="checkbox"/>	Visit 15 <input type="checkbox"/>	Visit 16 <input type="checkbox"/>	Visit 17 <input type="checkbox"/>	Visit 18 <input type="checkbox"/>
Visit 19 <input type="checkbox"/>	Visit 20 <input type="checkbox"/>	Visit 21 <input type="checkbox"/>	Visit 22 <input type="checkbox"/>	Visit 23 <input type="checkbox"/>	Visit 24 <input type="checkbox"/>

Please record here if you become an inpatient in any **non** Southmead Hospital or rehabilitation unit, or become resident in a nursing or residential home following **your initial discharge from the AOC for reasons relating to your hip replacement.**

Name of Hospital/ rehabilitation unit/ residential home/ nursing home	Total number of nights spent here since your initial discharge from the AOC following your hip replacement
	□ □
	□ □
	□ □
	□ □
	□ □
	□ □
	□ □

Please record here any visits to an outpatient department in any **non** Southmead Hospital or Accident and Emergency (A&E) Department following **your initial discharge from the AOC for reasons relating to your hip replacement.**

	Name of Hospital	Name of Outpatient Department (if visited A&E put A&E)
Visit 1		
Visit 2		
Visit 3		
Visit 4		
Visit 5		
Visit 6		
Visit 7		

Use of Social services for reasons relating to your hip replacement

Please record here if changes were made to your home (e.g grip rails, stair lift) or special equipment provided (e.g. commode, Toilet frame, Toilet seat, trolley) **since your initial discharge from the AOC for reasons relating to your hip replacement**

Changes to your home/ special equipment	Was this provided by social services	If you had to pay for this or contribute to the cost record approximately how much?
	Yes <input type="checkbox"/> No <input type="checkbox"/>	£
	Yes <input type="checkbox"/> No <input type="checkbox"/>	£
	Yes <input type="checkbox"/> No <input type="checkbox"/>	£
	Yes <input type="checkbox"/> No <input type="checkbox"/>	£
	Yes <input type="checkbox"/> No <input type="checkbox"/>	£
	Yes <input type="checkbox"/> No <input type="checkbox"/>	£

Please record number of Care Worker (Home help) visits following your initial discharge

Week since discharge	Number of visits	Week since discharge	Number of visits
1	<input type="text"/> <input type="text"/>	2	<input type="text"/> <input type="text"/>
3	<input type="text"/> <input type="text"/>	4	<input type="text"/> <input type="text"/>
5	<input type="text"/> <input type="text"/>	6	<input type="text"/> <input type="text"/>
7	<input type="text"/> <input type="text"/>	8	<input type="text"/> <input type="text"/>
9	<input type="text"/> <input type="text"/>	10	<input type="text"/> <input type="text"/>
11	<input type="text"/> <input type="text"/>	12	<input type="text"/> <input type="text"/>

Please record number of meals from Food at Home service (meals on wheels) following your initial discharge			
Week since discharge	Number of meals	Week since discharge	Number of meals
1	<input type="text"/> <input type="text"/>	2	<input type="text"/> <input type="text"/>
3	<input type="text"/> <input type="text"/>	4	<input type="text"/> <input type="text"/>
5	<input type="text"/> <input type="text"/>	6	<input type="text"/> <input type="text"/>
7	<input type="text"/> <input type="text"/>	8	<input type="text"/> <input type="text"/>
9	<input type="text"/> <input type="text"/>	10	<input type="text"/> <input type="text"/>
11	<input type="text"/> <input type="text"/>	12	<input type="text"/> <input type="text"/>

Record number of visits from a social worker following your initial discharge					
Visit 01 <input type="checkbox"/>	Visit 02 <input type="checkbox"/>	Visit 03 <input type="checkbox"/>	Visit 04 <input type="checkbox"/>	Visit 05 <input type="checkbox"/>	Visit 06 <input type="checkbox"/>

Record number of phone calls to a social worker following your initial discharge					
Call 01 <input type="checkbox"/>	Call 02 <input type="checkbox"/>	Call 03 <input type="checkbox"/>	Call 04 <input type="checkbox"/>	Call 05 <input type="checkbox"/>	Call 06 <input type="checkbox"/>
Call 07 <input type="checkbox"/>	Call 08 <input type="checkbox"/>	Call 09 <input type="checkbox"/>	Call 10 <input type="checkbox"/>	Call 11 <input type="checkbox"/>	Call 12 <input type="checkbox"/>

Record number of phone calls from a social worker following your initial discharge					
Call 01 <input type="checkbox"/>	Call 02 <input type="checkbox"/>	Call 03 <input type="checkbox"/>	Call 04 <input type="checkbox"/>	Call 05 <input type="checkbox"/>	Call 06 <input type="checkbox"/>
Call 07 <input type="checkbox"/>	Call 08 <input type="checkbox"/>	Call 09 <input type="checkbox"/>	Call 10 <input type="checkbox"/>	Call 11 <input type="checkbox"/>	Call 12 <input type="checkbox"/>

If you are having to pay for a home care worker, please note how much per visit
 £.....

If you are having to pay for food at home service, please note how much per midday meal
 and evening meal
 £.....
 £.....

Time off work and normal activities

If you are in paid work, please note how many days you have taken off paid work for **reasons relating to your hip replacement**.

Admission to hospital for your hip replacement days

Days off work you have had since discharge from hospital

Week since discharge	Number of days	Week since discharge	Number of days
1	<input type="text"/> <input type="text"/>	2	<input type="text"/> <input type="text"/>
3	<input type="text"/> <input type="text"/>	4	<input type="text"/> <input type="text"/>
5	<input type="text"/> <input type="text"/>	6	<input type="text"/> <input type="text"/>
7	<input type="text"/> <input type="text"/>	8	<input type="text"/> <input type="text"/>
9	<input type="text"/> <input type="text"/>	10	<input type="text"/> <input type="text"/>
11	<input type="text"/> <input type="text"/>	12	<input type="text"/> <input type="text"/>

Since your initial discharge from the AOC please note here how much time you have lost from your normal activities e.g. Caring duties, Voluntary work, Leisure, hobbies and social events, which you would normally do but couldn't do for **reasons relating to your hip replacement**.

Week since discharge	Number of hours lost per week	Week since discharge	Number of hours lost per week
1	<input type="text"/> <input type="text"/>	2	<input type="text"/> <input type="text"/>
3	<input type="text"/> <input type="text"/>	4	<input type="text"/> <input type="text"/>
5	<input type="text"/> <input type="text"/>	6	<input type="text"/> <input type="text"/>
7	<input type="text"/> <input type="text"/>	8	<input type="text"/> <input type="text"/>
9	<input type="text"/> <input type="text"/>	10	<input type="text"/> <input type="text"/>
11	<input type="text"/> <input type="text"/>	12	<input type="text"/> <input type="text"/>

Since your initial discharge from the AOC please note here how much time friends and relatives helped you with tasks at home (eg. Bathing, dressing, shopping, gardening), which you would normally do but couldn't do for **reasons relating to your hip replacement**.

Week since discharge	Number of hours they helped you per week	Week since discharge	Number of hours they helped you per week
1	<input type="text"/> <input type="text"/>	2	<input type="text"/> <input type="text"/>
3	<input type="text"/> <input type="text"/>	4	<input type="text"/> <input type="text"/>
5	<input type="text"/> <input type="text"/>	6	<input type="text"/> <input type="text"/>
7	<input type="text"/> <input type="text"/>	8	<input type="text"/> <input type="text"/>
9	<input type="text"/> <input type="text"/>	10	<input type="text"/> <input type="text"/>
11	<input type="text"/> <input type="text"/>	12	<input type="text"/> <input type="text"/>

If you visit a GP or Southmead Hospital during these 3 months, please note, the distance if travelling by car, or the costs of a return journey if travelling by bus/taxi, also how much you pay for car parking.

Car mileage to GP.....return. Cost of car parking £.....

Car mileage to SMH.....return. Cost of car parking £.....

Return Fare to GP £.....

Return Fare to SMH £.....

Use of Medications

Tick the relevant boxes to keep count of the number of prescriptions received **since your initial discharge from the AOC for reasons relating to your hip replacement**

Prescription 1 <input type="checkbox"/>	Prescription 2 <input type="checkbox"/>	Prescription 3 <input type="checkbox"/>	Prescription 4 <input type="checkbox"/>	Prescription 5 <input type="checkbox"/>
Prescription 6 <input type="checkbox"/>	Prescription 7 <input type="checkbox"/>	Prescription 8 <input type="checkbox"/>	Prescription 9 <input type="checkbox"/>	Prescription 10 <input type="checkbox"/>

Please record any prescribed medications or preparations (prescribed for you by a doctor) taken **since your initial discharge from the AOC for reasons relating to your hip replacement**

Name or brand of medicine or preparation and its strength <i>(copy name from the bottle/packet)</i> e.g Tramadol 100mg	What was the daily dose (e.g. number of tablets or spoonfuls of syrup per day)?	Date you began this medication	Date you stopped this medication
	mg		
	mg		
	mg		
	mg		
	mg		
	mg		
	mg		
	mg		

Please record here costs of non-prescribed (over the counter) medications you have purchased **since your initial discharge from the AOC for reasons relating to your hip replacement**

Cost of item 1		Cost of item 2	
Cost of item 3		Cost of item 4	
Cost of item 5		Cost of item 6	
Cost of item 7		Cost of item 8	
Cost of item 9		Cost of item 10	