

Date: __/__/__

Patient Survey (QoR – 40)

Name: _____ study #: _____ Hospital UR #: _____

PART A

How have you been feeling in the last 24 hours?

(1 to 5, where : 1 = very poor and 5 = excellent)

For example: If you have been able to breathe easily all of the time, you should indicate this by circling the response 5 = *all of the time* as shown below:

	None of the time	Some of the time	Usually	Most of the time	All of the time
Able to breathe easily	1	2	3	4	5

	None of the time	Some of the time	Usually	Most of the time	All of the time
Comfort					
Able to breathe easily	1	2	3	4	5
Have had a good sleep	1	2	3	4	5
Been able to enjoy food	1	2	3	4	5
Feel rested	1	2	3	4	5
Emotions					
Having a feeling of general well-being	1	2	3	4	5
Feeling in control	1	2	3	4	5
Feeling comfortable	1	2	3	4	5

How have you been feeling in the last 24 hours?

(1 to 5, where : 1 = very poor and 5 = excellent)

	None of the time	Some of the time	Usually	Most of the time	All of the time
Physical Independence					
Have normal speech	1	2	3	4	5
Able to wash, brush teeth or shave	1	2	3	4	5
Able to look after your own appearance	1	2	3	4	5
Able to write	1	2	3	4	5
Able to return to work or usual home activities	1	2	3	4	5
Patient Support					
Able to communicate with hospital staff (when in hospital)	1	2	3	4	5
Able to communicate with family or friends	1	2	3	4	5
Getting support from hospital doctors (when in hospital)	1	2	3	4	5
Getting support from hospital nurses (when in hospital)	1	2	3	4	5
Having support from family or friends	1	2	3	4	5
Able to understand instructions and advice	1	2	3	4	5

PART B

Have you had any of the following in the last 24 hours?

(5 to 1, where: 5 = excellent and 1 = very poor)

	None of the time	Some of the time	Usually	Most of the time	All of the time
Comfort					
Nausea	5	4	3	2	1
Vomiting	5	4	3	2	1
Dry-retching	5	4	3	2	1
Feeling restless	5	4	3	2	1
Shaking or twitching	5	4	3	2	1
Shivering	5	4	3	2	1
Feeling too cold	5	4	3	2	1
Feeling dizzy	5	4	3	2	1
Emotions					
Had bad dreams	5	4	3	2	1
Feeling anxious	5	4	3	2	1
Feeling angry	5	4	3	2	1
Feeling depressed	5	4	3	2	1
Feeling alone	5	4	3	2	1
Had difficulty falling asleep	5	4	3	2	1

Have you had any of the following in the last 24 hours?

(5 to 1, where: 5 = excellent and 1 = very poor)

	None of the time	Some of the time	Usually	Most of the time	All of the time
Patient Support					
Feeling confused	5	4	3	2	1
Pain					
Moderate pain	5	4	3	2	1
Severe pain	5	4	3	2	1
Headache	5	4	3	2	1
Muscle pains	5	4	3	2	1
Backache	5	4	3	2	1
Sore throat	5	4	3	2	1
Sore mouth	5	4	3	2	1

Thank you for your assistance.

Please check that all questions have been answered.

If you have any questions, please contact: Jenny Hunt or Helen Fletcher through the hospital's switchboard (03) 9276 2000.