**Brief Modified City of Hope

Questionnaire

February 2004

Please answer the following questions **based on your loved one's experience and your experience during the last 2 weeks of life**. Circle the number from 0 – 10 that best describes you and your loved one's experiences:

1. **To what extent were the following a problem for your loved one**:

   Shortness of breath or difficulty breathing

   No problem 0 1 2 3 4 5 6 7 8 9 10 *Severe problem*

   Aches or pain

   No problem 0 1 2 3 4 5 6 7 8 9 10 *Severe problem*

2. **Please rate your loved one's average pain level during those last 2 weeks**

   No pain 0 1 2 3 4 5 6 7 8 9 10 *Worst pain you can imagine*

3. **Rate your loved one's experience receiving effective and timely pain and symptom relief, e.g. difficulty breathing, nausea, constipation**

   No problem 0 1 2 3 4 5 6 7 8 9 10 *Severe problem*

4. **How satisfying were those last 2 weeks of life for your loved one**

   Not at all 0 1 2 3 4 5 6 7 8 9 10 *Completely*

5. **Was the amount of support you received and connection to others sufficient to meet your needs**

   Not at all 0 1 2 3 4 5 6 7 8 9 10 *Completely*

6. **How much difficulty did you have obtaining adequate help to meet your loved one's physical needs at home**

   NA *No problem* 0 1 2 3 4 5 6 7 8 9 10 *Severe problem*

7. **Were you given enough information about your loved one's care and treatment choices to prepare you for his/her care and treatments**

   Not at all 0 1 2 3 4 5 6 7 8 9 10 *Completely*

8. **Were you given enough information about signs of approaching death to prepare you for your loved one's dying and death**

   Not at all 0 1 2 3 4 5 6 7 8 9 10 *Completely*

9. **Were you given information about and access to professional counselors and support groups for yourself and your loved one or put in touch with others who had similar experiences**

   Not at all 0 1 2 3 4 5 6 7 8 9 10 *A great deal*

10. **Were you given a choice to have chaplains or others pray with you and your loved one**

    Not at all 0 1 2 3 4 5 6 7 8 9 10 *A great deal*

11. **Did people consistently follow through with you and your loved one's care wishes**

Not at all 0 1 2 3 4 5 6 7 8 9 10 *A great deal*

12. **Did you feel caring, respect, and genuine presence from your loved one's doctors, nurses and other health care providers.**

Not at all 0 1 2 3 4 5 6 7 8 9 10 *A great deal*

13. **Was your loved one's doctors' communication with you easy to understand and consistent**

Not at all 0 1 2 3 4 5 6 7 8 9 10 *A great deal*

14. **Was your loved one's nurses' communication with you easy to understand and consistent**

Not at all 0 1 2 3 4 5 6 7 8 9 10 *A great deal*

15. **Did you feel doctors were available for you and your loved one as you needed them**

Not at all 0 1 2 3 4 5 6 7 8 9 10 *A great deal*

16. **Did you feel nurses and other professionals were available for you and your loved one as you needed them**

Not at all 0 1 2 3 4 5 6 7 8 9 10 *A great deal*

17. **Did you feel supported by your loved one's doctors if you looked for second opinions and other care choices**

Not at all 0 1 2 3 4 5 6 7 8 9 10 *A great deal*

18. **Did your loved one's doctor(s) provide you the opportunity to discuss your loved one's approaching death and dying**

Not at all 0 1 2 3 4 5 6 7 8 9 10 *A great deal*

19. **Did your loved one's nurses and others provide you the opportunity to discuss your loved one's approaching death and dying**

Not at all 0 1 2 3 4 5 6 7 8 9 10 *A great deal*

20. **Since your loved one's death, how much opportunity have you had for follow-up contact with your loved one's doctors, nurses and other health care providers**

Not at all 0 1 2 3 4 5 6 7 8 9 10 *A great deal*

21. **Please rate your overall experience with the quality of your loved ones health services**

Very inconsistent 0 1 2 3 4 5 6 7 8 9 10 *Consistently high*

22. **Did your loved one die in the care environment where you or your loved one wished?**

___ Yes ___ NO

If yes, what services were most helpful in making that possible?
____

If not, why not? _____________________________________

Please share other comments about your experience

____

____

_______________**Modified by Supportive Care of the Dying: A Coalition for Compassionate Care

Information About You

Please complete the following questions about you. This information will be kept strictly confidential.

Age __________ **Gender**: ____Male ___Female

Race/Ethnicity
___White/Caucasian
___Black/African American
___Asian or Pacific Islander
___Hispanic
___Native American
___Other

Current Living Arrangements:
___Living alone at home
___Home with family / friends
___Living with family / friends in their home
___Assisted Living
___Nursing Home

Health Services you received:
___Home Health
___Hospice
___Parish Nurse
___Church based ministries, e.g. Stephen Ministries
___Visiting Nurse
___Other (specify): _________________________

Diagnosis or illness that was life – threatening for your loved one:
____

Place of your loved one's death ___home ___long term care ___hospital

Date of your loved one's death___________________________

Please call me about my loved one's care or this questionnaire ___yes ___no

Date questionnaires completed _______________ I.D. number_____________