APPENDIX

Center:

Alzheimer's Disease Cooperative Study
Prevention Instruments Protocol

Resource Use Inventory (Page 1 of 5)

Baseline Visit

Subject Number P I ☐☐☐-☐☐☐ Subject Initials ☐☐☐ Examiner Initials ☐☐☐ Examination Date ☐☐ Month ☐☐ Day ☐☐ Year

Instructions: **This questionnaire is designed to assess the health related services used during the past 3 months. Please ask your study partner to participate in answering these questions, so that you can record as much information as possible.**

Important: Please be sure to provide an answer for each item. If there were no services used for an item, record "00" in the appropriate box.

Who worked on this form:

- ☐ Self
- ☐ Study Partner
- ☐ Both Subject and Study Partner

1. In the past 3 months how many times were you admitted to the hospital? If none, enter "00" and skip to question 2.

☐☐ (Enter "00" if none)

Enter the reason for each admission:

REASON FOR ADMISSION	Number of Nights	For site use only Diagnosis Type (circle all that apply)
Example: Tonsillectomy	0 4	1 2 3 4 5 6
	☐☐	1 2 3 4 5 6
	☐☐	1 2 3 4 5 6
	☐☐	1 2 3 4 5 6

☐ Check here if supplemental form is used to record additional reasons for admission

2. In the past 3 months how many times were you examined by a doctor or nurse? This includes doctor, chiropracter, acupuncturist, emergency room visits, etc. This also includes someone who comes to your home, such as a visiting nurse or physical therapist.

TOTAL VISITS ☐☐ (Enter "00" if none)

a. Doctor visits ☐☐ c. Other _____ ☐☐

b. Nurse visits ☐☐ d. Other _____ ☐☐

Record the total number of visits in the box above

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3. For each item below, record the quantity you used or purchased in the past 3 months. Enter **"00"** if you did not use or purchase any.

	Quantity		Quantity
EYE GLASSES	☐☐	TOILET BARS	☐☐
CONTACT LENSES	☐☐	TOILET SEAT/chair	☐☐
HEARING AIDS	☐☐	TUB TRANSFER BENCH	☐☐
DENTURES	☐☐	SHOWER BENCH chair/stool/transfer seat	☐☐
JOINT BRACE ankle/wrist/knee	☐☐	HANDRAILS FOR SHOWER	☐☐
ELASTIC STOCKINGS	☐☐	HOSPITAL BED	☐☐
CANE/walking stick	☐☐	BED PADS (record number in last 3 months)	☐☐
CRUTCHES	☐☐	BED ALARM	☐☐
WALKER	☐☐	URINARY CATHETER	☐☐
RESTRAINTS	☐☐	DOOR ALARMS	☐☐
WHEEL CHAIR	☐☐	DIAPERS/pads/briefs (record number of items)	☐☐
LIFT CHAIR (ELECTRIC)	☐☐	OTHER: _____	☐☐
SAFETY BARS	☐☐	_____ (please list any other items purchased)	

☐ Check box if none, and skip to question 4.

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4. List any **outpatient** medical tests or procedures, or treatments required by you in the last 3 months (this includes any therapy, oxygen, social services, health education services, dental care, etc.). **Do not include inpatient procedures.**

☐ Check box if none, and skip to question 5.

MEDICAL TEST OR PROCEDURE FOR SUBJECT	Was part or all paid by Insurance?
Example: Vaccination for polio	1 ☑ Yes 0 ☐ No
	1 ☐ Yes 0 ☐ No
	1 ☐ Yes 0 ☐ No
	1 ☐ Yes 0 ☐ No

☐ Check here if supplemental form is used to record treatments/procedures

5. a) How many nights did you spend in "overnight care" **(not including hospital stays)** in the past 3 months (*e.g.,* rehabilitation center)? ***If none,*** enter "00" and skip to question 6.

☐☐ (Enter "00" if none)

Who paid for the time spent in "overnight care?"

Medicare	Other Insurance	You Paid
☐	☐	☐

You may check Yes to all that apply

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6. a) In the past 3 months, how many days did a home health aide, attendant, companion, or any other paid individual look after you? ***If None,*** enter "00" and skip to question 7. ☐☐ (Enter "00" if none)

b) For each day included in 6a, how many hours per day on average? ☐☐ (Enter "00" if none)

Who paid for the home health aide, attendant, companion, or any other paid individual?

Medicare	Other Insurance	You Paid
☐	☐	☐

You may check Yes to all that apply

These questions refer to how much assistance you receive from any non-paid help, such as other family members, friends or volunteers. ***Use the past 3 months to estimate.***

7. a) How many hours a week did helper(s) spend with you (assisting with things such as getting the phone or the door, getting around, or fetching things)? ☐☐ (Enter "00" if none)

b) How many hours a week did helper(s) spend with you on basic tasks such as eating, dressing or personal care (bathing, using toilet, brushing hair, etc.)? ☐☐ (Enter "00" if none)

c) How many hours a week did helper(s) spend helping you with activities such as shopping, chores, personal business, transportation, or social activities? ☐☐ (Enter "00" if none)

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8. Do you receive non-paid help with the following activities:

▸ *If you check Yes for any activity, record the number of hours help you receive.*

	Yes (1)	No (0)	Average # of hours/week	Who provides the help? (You may check all that apply) spouse	child	relative	friend	volunteer	other
shopping	☐	☐							
cleaning	☐	☐							
laundry	☐	☐							
meal preparation	☐	☐							
transportation	☐	☐							
personal finances	☐	☐							
dressing	☐	☐							
grooming (toileting, bathing, etc.)	☐	☐							

9a. Do you do volunteer work?

Yes ☐ **No** ☐

→ If yes, how many hours per week

9b. Are you engaged in paid employment?

Yes ☐ **No** ☐

→ If yes, how many hours per week

9c. In the past 3 months, have you lost time in volunteer work or paid employment due to health reasons?

Yes ☐ **No** ☐

→ If yes, how many hours per week

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