

## Asian Patient Perspectives Regarding Oncology Awareness, Care, and Health (APPROACH)

**For interviewer: Fill in the following information after you have completed the questionnaire.**

PARTICIPANT CODE:  DATE OF INTERVIEW    /   /     
(FROM CONSENT FORM) (DD/MM/YYYY):

TIME STARTED:                      TIME ENDED:                      TOTAL INTERVIEW TIME:

INTERVIEWER NAME:

COUNTRY:    INTERVIEW LANGUAGE:

NAME OF THE INSTITUTION:

PATIENT TYPE: 1 OUTPATIENT                      2 INPATIENT

SITE OF RECRUITMENT:

- 1 DEPARTMENT OF MEDICAL ONCOLOGY
- 5 DEPARTMENT OF SURGERY
- 6 INTERNATIONAL MEDICAL DEPARTMENT
- 7 DEPARTMENT OF RADIATION ONCOLOGY
- 8 PALLIATIVE CARE UNIT
- 9 OTHER, \_\_\_\_\_
- 10 ONCOLOGY DEPARTMENT, HUE CENTRAL HOSPITAL BASE 2

**Fill in the  
information from  
patient's medical  
records.**

PATIENT GENDER: 1 MALE 2 FEMALE

PATIENT'S DATE OF BIRTH (DD/MM/YYYY):    /   /   

TYPE OF CANCER: \_\_\_\_\_

## INTRODUCTION

We are conducting a survey to understand the quality of life of patients, quality of care they are currently receiving and their treatment preferences. Your opinions are important to the success of this study. The survey usually takes about **45 minutes**.

There are no right or wrong answers to the questions and you do not have to respond to any questions that you feel uncomfortable answering. Your identity and the information given will be kept strictly confidential and only group data will be reported.

## SECTION S: SCREENER

**S1 Have you ever been diagnosed with any of the following health conditions? Check all that apply.**

	Health Conditions	Yes
<input type="checkbox"/> 1	Diabetes	<input type="checkbox"/>
<input type="checkbox"/> 2	Heart conditions (e.g. heart attack, blocked blood vessels)	<input type="checkbox"/>
<input type="checkbox"/> 3	Lung/Liver disease (e.g. bronchitis, hepatitis)	<input type="checkbox"/>
<input type="checkbox"/> 4	Cancer	<input type="checkbox"/>

**[TERMINATE if option 4 'Cancer' is NOT checked]**

**[Thank you for your interest, but you are not eligible to continue with this survey]**

**SECTION A: BASIC INFORMATION**

[For questions A1 to A5, you do not need to read the response choices out loud to the patient. Allow the patient to first respond directly, and prompt him/her with relevant choices depending upon his/her response]

Refuse to answer

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<b>A1 What is your age?</b>			
<input type="text"/>		years old	
<b>A2 How many years of education have you completed (including higher education)?</b>			
<input type="text"/>		years	
<b>A3 What is your current marital status?</b>			
<input type="checkbox"/> 1	Married	<input type="checkbox"/> 4	Divorced
<input type="checkbox"/> 2	Separated	<input type="checkbox"/> 5	Never married
<input type="checkbox"/> 3	Widowed	<input type="checkbox"/> 6	Other, specify: _____
<b>A4 What is your religion?</b>			
<input type="checkbox"/> 1	Hindu	<input type="checkbox"/> 7	Jewish
<input type="checkbox"/> 2	Muslim	<input type="checkbox"/> 8	Parsi/Zoroastrian
<input type="checkbox"/> 3	Christian (including Roman Catholic, Protestant, Orthodox, other)	<input type="checkbox"/> 9	Taoist
<input type="checkbox"/> 4	Sikh	<input type="checkbox"/> 10	Confucian
<input type="checkbox"/> 5	Buddhist	<input type="checkbox"/> 11	No religion
<input type="checkbox"/> 6	Jain	<input type="checkbox"/> 12	Other, specify: _____

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<b>A4.3 What is your ethnicity?</b>			
<input type="checkbox"/> 30	Kinh	<input type="checkbox"/> 33	Mường
<input type="checkbox"/> 31	Tày	<input type="checkbox"/> 17	Others
<input type="checkbox"/> 32	Thái		
<b>A5 What type of cancer have you been diagnosed with?</b>			
<input type="checkbox"/> 1	Bladder	<input type="checkbox"/> 11	Lung
<input type="checkbox"/> 2	Brain	<input type="checkbox"/> 12	Nasopharyngeal
<input type="checkbox"/> 3	Breast	<input type="checkbox"/> 13	Oesophageal
<input type="checkbox"/> 4	Cervical	<input type="checkbox"/> 14	Ovarian
<input type="checkbox"/> 5	Colorectal	<input type="checkbox"/> 15	Oral
<input type="checkbox"/> 6	Endometrial	<input type="checkbox"/> 16	Pancreatic
<input type="checkbox"/> 7	Gastric	<input type="checkbox"/> 17	Prostate
<input type="checkbox"/> 8	Intestinal	<input type="checkbox"/> 18	Vulva
<input type="checkbox"/> 9	Kidney	<input type="checkbox"/> 19	Others, please specify _____
<input type="checkbox"/> 10	Liver	<input type="checkbox"/> 20	Don't know
<b>A6 Do you know the current stage (i.e. severity) of your cancer?</b>			
<input type="checkbox"/> 1	Early Stage (Stage I, II or III)		
<input type="checkbox"/> 2	Advanced Stage (Stage IV)		
<input type="checkbox"/> 3	I don't know		
<b>A7 [If A6=2] What was the stage (i.e. severity) of your cancer when you <u>first</u> learned about it?</b>			
<input type="checkbox"/> 1	Early Stage (Stage I, II or III)		
<input type="checkbox"/> 2	Advanced Stage (Stage IV)		
<input type="checkbox"/> 3	I don't know		

**SECTION B: QUALITY OF LIFE**

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**B1<sup>1</sup>** Below is a list of statements that other people with your illness have said are important or bothersome for them. Some of the items may appear to be repetitive, but please bear with us. Please indicate one number per line as it applies to the past 7 days.

		Not at all	A little bit	Some-what	Quite a bit	Very much
B1.1 GP3	Because of my physical condition, I have trouble meeting the needs of my family	0	1	2	3	4
B1.2 GP5	I am bothered by side effects of treatment	0	1	2	3	4
B1.3 GP6	I feel ill	0	1	2	3	4
B1.4 GP7	I am forced to spend time in bed	0	1	2	3	4
		Not at all	A little bit	Some-what	Quite a bit	Very much
B1.5 GS1	I feel close to my friends	0	1	2	3	4
B1.6 GS2	I get emotional support from my family	0	1	2	3	4
B1.7 GS3	I get support from my friends	0	1	2	3	4
B1.8 GS4	My family has accepted my illness	0	1	2	3	4
B1.9 GS5	I am satisfied with family communication about my illness	0	1	2	3	4
B1.10 GS6	I feel close to my partner (or the person who is my main support)	0	1	2	3	4
<i>Regardless of your current level of sexual activity, please answer the following question. If you prefer not to answer it, please mark this box <input type="checkbox"/> and go to the next question.</i>						
B1.11 GS7	I am satisfied with my sex life	0	1	2	3	4

<sup>1</sup> Items in B1 are from the Functional Assessment of Chronic Illness Therapy system of Quality of Life questionnaires ("FACIT system"). Items B1.1–B1.24 are from FACT-G (Version 4), Items B1.25–B1.36 are from FACIT-Sp (Version 4) and B1.37 from FACIT-Pal (Version 4).

		Not at all	A little bit	Some-what	Quite a bit	Very much
B1.12 GE1	I feel sad	0	1	2	3	4
		Not at all	A little bit	Some-what	Quite a bit	Very much
B1.13 GE2	I am satisfied with how I am coping with my illness	0	1	2	3	4
B1.14 GE3	I am losing hope in the fight against my illness	0	1	2	3	4
B1.15 GE4	I feel nervous	0	1	2	3	4
B1.16 GE5	I worry about dying	0	1	2	3	4
B1.17 GE6	I worry that my condition will get worse	0	1	2	3	4
		Not at all	A little bit	Some-what	Quite a bit	Very much
B1.18 GF1	I am able to work (include work at home)	0	1	2	3	4
B1.19 GF2	My work (include work at home) is fulfilling	0	1	2	3	4
B1.20 GF3	I am able to enjoy life	0	1	2	3	4
B1.21 GF4	I have accepted my illness	0	1	2	3	4
B1.22 GF5	I am sleeping well	0	1	2	3	4
B1.23 GF6	I am enjoying the things I usually do for fun	0	1	2	3	4
B1.24 GF7	I am content with the quality of my life right now	0	1	2	3	4
		Not at all	A little bit	Some-what	Quite a bit	Very much
B1.25 Sp1	I feel peaceful	0	1	2	3	4
B1.26 Sp2	I have a reason for living	0	1	2	3	4
B1.27 Sp3	My life has been productive	0	1	2	3	4

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B1.28 Sp4	I have trouble feeling peace of mind	0	1	2	3	4
B1.29 Sp5	I feel a sense of purpose in my life	0	1	2	3	4
		<b>Not at all</b>	<b>A little bit</b>	<b>Some-what</b>	<b>Quite a bit</b>	<b>Very much</b>
B1.30 Sp6	I am able to reach down deep into myself for comfort	0	1	2	3	4
B1.31 Sp7	I feel a sense of harmony within myself	0	1	2	3	4
B1.32 Sp8	My life lacks meaning and purpose	0	1	2	3	4
B1.33 Sp9	I find comfort in my faith or spiritual beliefs	0	1	2	3	4
B1.34 Sp10	I find strength in my faith or spiritual beliefs	0	1	2	3	4
B1.35 Sp11N I	Difficult times have strengthened my faith or spiritual beliefs	0	1	2	3	4
B1.36 Sp12N I	Even during difficult times, I know that things will be okay	0	1	2	3	4
B1.37 Sp21	I feel hopeful	0	1	2	3	4

The next three questions will focus on your finances.

<b>B2</b>	<b>How well does the amount of money you have enable you to cover the cost of your treatment?</b>
<input type="checkbox"/> 1	Very well
<input type="checkbox"/> 2	Fairly well
<input type="checkbox"/> 3	Poorly
<b>B3</b>	<b>How well does the amount of money you have take care of your daily needs?</b>
<input type="checkbox"/> 1	Very well
<input type="checkbox"/> 2	Fairly well
<input type="checkbox"/> 3	Poorly
<b>B4</b>	<b>How well does the amount of money you have enable you to buy those little 'extras', that is, those small luxuries?</b>
<input type="checkbox"/> 1	Very well
<input type="checkbox"/> 2	Fairly well

<input type="checkbox"/> 3	Poorly
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<b>B10.1 In the last 24 hours, have you taken any medication for pain relief?</b>	
<input type="checkbox"/> 1	Yes
<input type="checkbox"/> 2	No

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Refuse to answer

<b>B13</b> Below is a list of symptoms that people with your illness commonly experience. Please circle or mark one number per line to indicate your response as it applies to the <u>past 7 days</u> .						
<sup>2</sup>						
	<b>SYMPTOM MANAGEMENT</b>	<b>Not at all</b>	<b>A little bit</b>	<b>Some-what</b>	<b>Quite a bit</b>	<b>Very much</b>
B13.1 GP4	I have pain	0	1	2	3	4
B13.2 B1	I have been short of breath	0	1	2	3	4
B13.3 PAL5	I am constipated	0	1	2	3	4
B13.4 C2	I am losing weight	0	1	2	3	4
B13.5 O2	I have been vomiting	0	1	2	3	4
B13.6 PAL6	I have swelling in parts of my body	0	1	2	3	4
B13.7 PAL7	My mouth and throat are dry	0	1	2	3	4
B13.8 GP1	I have lack of energy	0	1	2	3	4
B13.9 GP2	I have nausea	0	1	2	3	4
B13.10	Any other symptom, please specify: _____		1	2	3	4
<b>B14 (If any of B13.1 to B13.10 ≠0) Did you tell your doctor about your symptoms?</b>						
<input type="checkbox"/> 1	Yes					
<input type="checkbox"/> 2	No					

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<sup>2</sup> Items B13.1–B13.6 are from FACIT-Pal (Version 4) and B13.8–B13.9 are from FACT-G (Version 4). Both FACIT-Pal and FACT-G are from the Functional Assessment of Chronic Illness Therapy system of Quality of Life questionnaires (“FACIT system”).



**B15 (If B14=2) Why did you not tell your doctor about your symptoms? Check all that apply.**

<input type="checkbox"/> 1	I can manage my symptoms myself
<input type="checkbox"/> 2	I want the doctor to focus on the treatment of my cancer
<input type="checkbox"/> 3	I did not get an opportunity to tell the doctor
<input type="checkbox"/> 4	I believe that it is easier to put up with symptoms than with the side effects that come from medicines to treat these symptoms.
<input type="checkbox"/> 5	I will use medicines only as a last resort to treat my symptoms
<input type="checkbox"/> 6	I believe that good patients avoid talking about symptom/s
<input type="checkbox"/> 7	I can get addicted easily to medicines needed to treat these symptoms
<input type="checkbox"/> 8	I believe that tolerating symptoms builds character—it's good for me.
<input type="checkbox"/> 9	Any other reason, specify _____
<input type="checkbox"/> 10	I believe that tolerating pain and symptoms would help me get rid of my sins.

**B16** Below is a list of the ways you might have felt or behaved. For each of the following statements, please choose the option that best describes how often you felt or behaved this way during the PAST WEEK.

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		Rarely or none of the time (Less than 1 day)	Some or a little of the time (1-2 days)	Occasionally or a moderate amount of the time (3-4 days)	Most or all of the time (5-7 days)
B16.15.1	I was bothered by things that usually don't bother me.	1	2	3	4
B16.15.2	I did not feel like eating; my appetite was poor.	1	2	3	4

<sup>3</sup> Items from B16.15 are from the CES-D 20-item scale. Radloff, L.S. (1977). The CES-D scale: A self-report depression scale for research in the general population. Applied psychological measurement, 1(3), 385-401.

B16.15.3	I felt that I could not shake off the blues even with help from my family or friends.	1	2	3	4	<input type="checkbox"/> 888
B16.15.4	I felt that I was just as good as other people.	1	2	3	4	<input type="checkbox"/> 888 Refuse to answer
B16.15.5	I had trouble keeping my mind on what I was doing.	1	2	3	4	<input type="checkbox"/> 888
B16.15.6	I felt depressed.	1	2	3	4	<input type="checkbox"/> 888
B16.15.7	I felt that everything I did was an effort.	1	2	3	4	<input type="checkbox"/> 888
B16.15.8	I felt hopeful about the future.	1	2	3	4	<input type="checkbox"/> 888
B16.15.9	I thought my life had been a failure.	1	2	3	4	<input type="checkbox"/> 888
B16.15.10	I felt fearful.	1	2	3	4	<input type="checkbox"/> 888
B16.15.11	My sleep was restless.	1	2	3	4	<input type="checkbox"/> 888
B16.15.12	I was happy.	1	2	3	4	<input type="checkbox"/> 888
B16.15.13	I talked less than usual.	1	2	3	4	<input type="checkbox"/> 888
B16.15.14	I felt lonely.	1	2	3	4	<input type="checkbox"/> 888
B16.15.15	People were very unfriendly.	1	2	3	4	<input type="checkbox"/> 888
B16.15.16	I enjoyed life.	1	2	3	4	<input type="checkbox"/> 888
B16.15.17	I had crying spells.	1	2	3	4	<input type="checkbox"/> 888
B16.15.18	I felt sad.	1	2	3	4	<input type="checkbox"/> 888
B16.15.19	I felt that people dislike me.	1	2	3	4	<input type="checkbox"/> 888
B16.15.20	I could not get "going".	1	2	3	4	<input type="checkbox"/> 888

<b>B17 I feel like I have become a burden on my loved ones.</b>	
<input type="checkbox"/> 1	Not at all
<input type="checkbox"/> 2	A little bit
<input type="checkbox"/> 3	Somewhat

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<input type="checkbox"/> 4	Quite a bit
<input type="checkbox"/> 5	Very much

**SECTION C: QUALITY OF CARE**

Refuse to answer

<b>C1<sup>4</sup> Now we would like to ask you some questions related to your experience in dealing with health care providers for your current illness. Think of all the healthcare providers (doctors, nurses, and allied health providers) that you have seen for your current illness since it was diagnosed. These include those in the hospital, polyclinics, private clinics, hospice, nursing homes or other places.</b>		<b>Always (1)</b>	<b>Somet imes (2)</b>	<b>Never (3)</b>	<b>Not applicable (4)</b>
<b>C1.1</b>	How often did your doctors listen carefully to you?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>C1.2</b>	How often did your doctors explain things in a way you could understand?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>C1.3</b>	How often did your doctors give you as much information as you wanted about your treatments, including potential benefits and side effects?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>C1.4</b>	How often did your doctors encourage you to ask all the cancer related questions you had?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>C1.5</b>	How often did your doctor treat you with courtesy and respect?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>C1.5.1</b>	How often did your doctors spend adequate time with you to address all your concerns?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>C1.6</b>	How often were your nurses as helpful as you thought they should be?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>C1.7</b>	How often did your nurses treat you with courtesy and respect?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>C1.8</b>	How often did you think that your health problems related to your cancer or its treatment were handled quickly enough?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>C1.9</b>	How often were you able to see the specialist doctors you wanted to see for your cancer?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>C1.10</b>	How often did the doctors, nurses, and other medical staff providing your care seem to work well together as a team?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

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<b>C1.11</b>	How often did your doctors seem to be aware of treatments for your cancer that other doctors recommended?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>C1.12</b>	How often did you know who to ask when you had any questions related to your cancer or its treatments?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>C1.13</b>	How often did you feel that your doctors, nurses, and other medical staff did everything they could to treat your health problems related to your cancer or its treatments?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>C1.14</b>	How often did you feel you were as much involved in decisions about your care as you wanted?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>C1.15</b>	<b>Overall how would you rate the quality of your health care since your diagnosis?</b>				
	<input type="checkbox"/> 1	Excellent	<input type="checkbox"/> 4	Fair	
	<input type="checkbox"/> 2	Very good	<input type="checkbox"/> 5	Poor	
	<input type="checkbox"/> 3	Good			

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<b>C2</b>						
<b>Now I would like you to think about your most recent visit again. I want to know your impressions of your most recent visit for health care. I would like you to rate your experiences using the following questions.</b>						
For your last visit to a health care provider, how would you rate the following:						
		Very Good	Good	Moderate	Bad	Very Bad
C2.1	...your experience of being treated respectfully?	1	2	3	4	5
C2.2	...how clearly health care providers explained things to you?	1	2	3	4	5

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<sup>4</sup> Items from C1 except for C1.5.1 and C1.14 are from CanCORS Full Patient Baseline Interview (Version 7); Ayanian JZ, Zaslavsky AM, Arora NK, Kahn KL, Malin JL, Ganz PA, van Ryn M, Hornbrook MC, Kiefe CI, He Y, Urmie J, Weeks JC, Harrington DP. Patients' experiences with care for lung cancer and colorectal cancer: findings from the Cancer Care Outcomes Research and Surveillance Consortium. J Clin Oncol 2010; 28:4154-61.

Malin JL, Ko C, Ayanian JZ, Harrington D, Kahn KL, Ganther-Urmie J, Catalano PJ, Nerenz DR, Zaslavsky AM, Wallace RB, Guadagnoli E, Arora NK, Roudier MD, Ganz PA. Understanding cancer patients' experiences and outcomes: development and pilot study of the Cancer Care Outcomes Research and Surveillance patient survey. Supp Care Cancer 2006; 14:837-48.

C2.3	...your experience of being involved in making decisions for your treatment?	1	2	3	4	5
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Refuse to answer



<b>C3<sup>5</sup></b>	I am now going to read you stories describing experiences that other people with your illness have had with health care services. I want you to think about these people's experiences as if they were your own. Once I have finished reading each story, I will ask you to rate what happened in the story as very good, good, moderate, bad or very bad.					
C3.1	[Tý] went to a crowded clinic. No-one greeted her. She waited for 30 minutes when a nurse called for her for an examination behind a screen that separated the waiting area from the examination area.					
	How would you rate [Tý's] experience of being greeted and talked to respectfully?...	Very Good	Good	Moderate	Bad	Very Bad
		1	2	3	4	5
C3.2	The doctor has very briefly explained to [Tấn] about his illness. He is very busy and there is a queue of patients waiting to see him. [Tấn] would like to know more about his illness, but feels that there is no time to ask questions. The doctor says goodbye to [Tấn], and [Tấn] leaves the office.					
	How would you rate [Tấn] experience of how clearly health care providers explained things to him?	Very Good	Good	Moderate	Bad	Very Bad
		1	2	3	4	5
C3.3	The doctor ordered some blood tests and scan for [Hàn]. [Hàn] didn't know why he needed blood tests and scan and was worried until the doctor explained what they were for.					
	How would you rate [Hàn's] experience of being involved in making decisions about his health care or treatment?	Very Good	Good	Moderate	Bad	Very Bad
		1	2	3	4	5

<sup>5</sup> Adapted from WHO SAGE Wave 1 Individual questionnaire obtained from <http://www.who.int/healthinfo/sage/cohorts/en/index2.html>.

**SECTION D: PROGNOSIS, TREATMENT PREFERENCES, AND DECISION MAKING**

<b>D1 (If A6 ≠ 2) When did you <u>first</u> learn that you have cancer?</b>			
<input type="checkbox"/> 1	Less than 6 months ago	<input type="checkbox"/> 4	2 to 3 years ago
<input type="checkbox"/> 2	6 months to 1 year ago	<input type="checkbox"/> 5	More than 3 years ago
<input type="checkbox"/> 3	1 to 2 years ago		
<b>D2 (If A6 ≠ 2) Who informed you about it?</b>			
<input type="checkbox"/> 1	Doctor	<input type="checkbox"/> 4	Guessed from the worsened condition
<input type="checkbox"/> 2	Family member	<input type="checkbox"/> 5	Other, please explain: _____
<input type="checkbox"/> 3	Learned by chance		
<b>D3 (If A6 = 2) When did you <u>first</u> learn that you have <u>advanced</u> cancer?</b>			
<input type="checkbox"/> 1	Less than 6 months ago	<input type="checkbox"/> 4	2 to 3 years ago
<input type="checkbox"/> 2	6 months to 1 year ago	<input type="checkbox"/> 5	More than 3 years ago
<input type="checkbox"/> 3	1 to 2 years ago		
<b>D4 (If A6 = 2) Who informed you about it?</b>			
<input type="checkbox"/> 1	Doctor	<input type="checkbox"/> 4	Guessed from the worsened condition
<input type="checkbox"/> 2	Family member	<input type="checkbox"/> 5	Other, please explain: _____
<input type="checkbox"/> 3	Learned by chance		
<b>D5<sup>6</sup> How informed are you regarding how your illness will change over time?</b>			
<input type="checkbox"/> 1	Very informed	<input type="checkbox"/> 3	Unsure
<input type="checkbox"/> 2	Somewhat informed	<input type="checkbox"/> 4	Not informed

<sup>6</sup> CanCORS Full Patient Baseline Interview (Version 7); Ayanian JZ, Zaslavsky AM, Arora NK, Kahn KL, Malin JL, Ganz PA, van Ryn M, Hornbrook MC, Kiefe CI, He Y, Urmie J, Weeks JC, Harrington DP. Patients' experiences with care for lung cancer and colorectal cancer: findings from the Cancer Care Outcomes Research and Surveillance Consortium. J Clin Oncol 2010; 28:4154-61.

Malin JL, Ko C, Ayanian JZ, Harrington D, Kahn KL, Ganther-Urmie J, Catalano PJ, Nerenz DR, Zaslavsky AM, Wallace RB, Guadagnoli E, Arora NK, Roudier MD, Ganz PA. Understanding cancer patients' experiences and outcomes: development and pilot study of the Cancer Care Outcomes Research and Surveillance patient survey. Supp Care Cancer 2006; 14:837-48.

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The next items ask what you think about the possible results of cancer treatments. Do you think ...

<b>D6<sup>6</sup> The current treatments you are taking for your cancer will help you live longer?</b>	
<input type="checkbox"/> 1	Yes
<input type="checkbox"/> 2	No
<input type="checkbox"/> 3	Not sure
<b>D7<sup>6</sup> The current treatments you are taking for your cancer will cure you?</b>	
<input type="checkbox"/> 1	Yes
<input type="checkbox"/> 2	No
<input type="checkbox"/> 3	Not sure
<b>D8 There are other treatments (besides your current treatment) that will help you live longer?</b>	
<input type="checkbox"/> 1	Yes
<input type="checkbox"/> 2	No
<input type="checkbox"/> 3	Not sure
<b>D9 There are other treatments (besides your current treatment) that will cure you?</b>	
<input type="checkbox"/> 1	Yes
<input type="checkbox"/> 2	No
<input type="checkbox"/> 3	Not sure
<b>D10<sup>6</sup> Since diagnosis, who has been responsible for the most important decisions about your treatment? Check all that apply.</b>	
<input type="checkbox"/> 1	Myself
<input type="checkbox"/> 2	My family
<input type="checkbox"/> 3	My doctors
<b>D11<sup>6</sup> (If more than one option is checked in D10.) Which statement best describes the role each person played when making decisions about your treatment?</b>	
<i>(If "myself" and "my family" are checked, options are)</i>	
<input type="checkbox"/> 1	I made the decisions after considering my family's opinion
<input type="checkbox"/> 2	My family made the decisions after considering my opinion
<input type="checkbox"/> 3	My family and I made the decisions together
<i>(If "myself" and "my doctors" are checked, options are)</i>	
<input type="checkbox"/> 4	I made the decisions after considering my doctors' opinions
<input type="checkbox"/> 5	My doctors made the decisions after considering my opinion
<input type="checkbox"/> 6	My doctors and I made the decisions together

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Refuse to answer



<b><i>(If “my family” and “my doctors” are checked, options are)</i></b>	
<input type="checkbox"/> 7	My family made the decisions after considering my doctors’ opinions
<input type="checkbox"/> 8	My doctors made the decisions after considering my family’s opinion
<input type="checkbox"/> 9	My family and my doctors made the decisions together
<b><i>(If all three are checked, options are)</i></b>	
<input type="checkbox"/> 10	I made the decisions after considering my family’s and doctors’ opinions
<input type="checkbox"/> 11	My family made the decisions after considering my and my doctors’ opinions
<input type="checkbox"/> 12	My doctors made the decisions after considering my and my family’s opinions
<input type="checkbox"/> 13	My family, my doctors and I made the decisions together
<b>D12</b> 6	<b>Since diagnosis, who do you wish had been responsible for the most important decisions about your treatment? Check all that apply.</b>
<input type="checkbox"/> 1	Myself
<input type="checkbox"/> 2	My family
<input type="checkbox"/> 3	My doctors
<b>D13</b> 6	<b>(If more than one option is checked in D12.) Which statement best describes the role you wish each person had played when making decisions about your treatment?</b>
<b><i>(If “myself” and “my family” are checked, options are)</i></b>	
<input type="checkbox"/> 1	I wish that I made the decisions after considering my family’s opinion
<input type="checkbox"/> 2	I wish that my family made the decisions after considering my opinion
<input type="checkbox"/> 3	I wish that my family and I made the decisions together
<b><i>(If “myself” and “my doctors” are checked, options are)</i></b>	
<input type="checkbox"/> 4	I wish that I made the decisions after considering my doctors’ opinions
<input type="checkbox"/> 5	I wish that my doctors made the decisions after considering my opinion
<input type="checkbox"/> 6	I wish that my doctors and I made the decisions together
<b><i>(If “my family” and “my doctors” are checked, options are)</i></b>	
<input type="checkbox"/> 7	I wish that my family made the decisions after considering my doctors’ opinions
<input type="checkbox"/> 8	I wish that my doctors made the decisions after considering my family’s opinion
<input type="checkbox"/> 9	I wish that my family and my doctors made the decisions together
<b><i>(If all three are checked, options are)</i></b>	
<input type="checkbox"/> 10	I wish that I made the decisions after considering my family’s and doctors’ opinions
<input type="checkbox"/> 11	I wish that my family made the decisions after considering my and my doctors’ opinions

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<input type="checkbox"/> 12	I wish that my doctors made the decisions after considering my and my family's opinions
<input type="checkbox"/> 13	I wish that I, my family and my doctors made the decisions together
<b>D14 If there is a difference in opinion between you and your family regarding the appropriate course of treatment for you, whose opinion do you think will be <u>most important</u> in deciding the treatment that you receive?</b>	
<input type="checkbox"/> 1	My own
<input type="checkbox"/> 2	My family's
<input type="checkbox"/> 3	My doctor's

Refuse to answer

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We will now ask you questions about your treatment preferences. *The next questions that I am going to ask you are very sensitive in nature. Please skip the questions that you do not feel comfortable answering.*

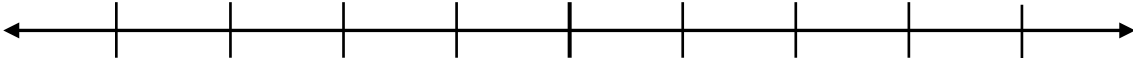
**D15<sup>6</sup> If you had to make a choice now, would you prefer treatment that extends life as much as possible, or would you want treatment that gives you minimal pain and discomfort? Please choose a point in the scale below.**



Extend life as much as possible Severe pain or discomfort	Moderate life extension Moderate pain or discomfort	No life extension Minimal pain or discomfort
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**D16<sup>6</sup> If you had to make a choice now, would you prefer treatment that extends life as much as possible, or would you want treatment that costs you less? Please choose a point in the scale below.**



Extend life as much as possible High cost	Moderate life extension Moderate cost	No life extension Less cost
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**D17 Have you discussed your treatment and care preferences with your family member(s)?**

<input type="checkbox"/> 1 Yes	<input type="checkbox"/> 2 No
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**SECTION E: HOSPICE PALLIATIVE CARE AWARENESS AND UTILIZATION**

Refuse to answer

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<b>E1<sup>6</sup> Please indicate if you are aware of hospice palliative care services? (Hospice palliative care is a comprehensive program that focuses on providing relief of pain and other distressing symptoms, as well as ensuring emotional, spiritual and practical support for the patient and the family. These services can be given in the patient's home, in an in-patient hospice, hospice day care centre, in a palliative care clinic or in the ward of a hospital)</b>			
<input type="checkbox"/> 1	Yes		
<input type="checkbox"/> 2	No (Go to E8)		
<input type="checkbox"/> 3	Not sure (Go to E8)		
<b>E2 How did you first learn about hospice palliative care services?</b>			
<input type="checkbox"/> 1	From doctors or other healthcare professionals	<input type="checkbox"/> 4	From the media
<input type="checkbox"/> 2	From family/friends	<input type="checkbox"/> 5	From others, please specify: _____
<input type="checkbox"/> 3	Through personal research		
<b>E3<sup>6</sup> Did any doctor or other health care provider <u>recommend</u> hospice palliative care to you?</b>			
<input type="checkbox"/> 1	Yes		
<input type="checkbox"/> 2	No (Go to E5)		
<input type="checkbox"/> 3	Not sure (Go to E5)		
<b>E4 When did the doctor recommend hospice palliative care for you?</b>			
<input type="checkbox"/> 1	Within the last month	<input type="checkbox"/> 4	1 year ago
<input type="checkbox"/> 2	2 to 3 months ago	<input type="checkbox"/> 5	More than 1 year ago
<input type="checkbox"/> 3	4 to 6 months ago		
<b>E5<sup>6</sup> Since the diagnosis of your illness, have you received hospice palliative care?</b>			
<input type="checkbox"/> 1	Yes		
<input type="checkbox"/> 2	No (Go to E7)		
<input type="checkbox"/> 3	Not sure (Go to E7)		
<b>E6<sup>6</sup> (If E5=1) Please tell us who had the FINAL say in deciding for you to receive hospice palliative care.</b>			
<input type="checkbox"/> 1	Me only	<input type="checkbox"/> 5	Me and my doctor
<input type="checkbox"/> 2	My family only	<input type="checkbox"/> 6	My family and my doctor
<input type="checkbox"/> 3	My doctor only	<input type="checkbox"/> 7	Me, my family and my doctor
<input type="checkbox"/> 4	Me and my family	<input type="checkbox"/> 8	Others, please specify: _____



**E7** [You do not need to read response choices out loud. Allow the patient to first respond directly, and prompt him/her with relevant choices depending upon his/her response]  
**(If E5#1) Why are you not receiving hospice palliative care at this time? Check all that apply.**

<input type="checkbox"/> 1	I am still receiving treatment for my disease
<input type="checkbox"/> 2	I do not believe it's time for hospice palliative care
<input type="checkbox"/> 3	I do not think that hospice palliative care would be of help to me
<input type="checkbox"/> 4	Some of my doctors do not think that hospice palliative care would be of help to me
<input type="checkbox"/> 5	My family does not believe it's time for hospice palliative care
<input type="checkbox"/> 6	My family does not think that hospice palliative care would be of help to me
<input type="checkbox"/> 7	I don't know much about it
<input type="checkbox"/> 8	I think getting hospice palliative care will be like giving up on life
<input type="checkbox"/> 9	It is expensive
<input type="checkbox"/> 10	Any other reason, please specify: _____

***The next questions that I am going to ask you are very sensitive in nature. We are asking you these questions to better understand your thoughts on your health, quality of life and the quality of care you receive from this hospital. Please skip the questions that you do not feel comfortable answering.***



**E8** **Would you like to know how long you are likely to live under various treatment options?**

<input type="checkbox"/> 1	No
<input type="checkbox"/> 2	Yes, in general terms (such as 'a few months' or 'a few years')
<input type="checkbox"/> 3	Yes, in specific terms (such as 'on average 6 months')
<input type="checkbox"/> 4	Not Sure



**E9** [You do not need to read response choices out loud. Allow the patient to first respond directly, and prompt him/her with relevant choices depending upon his/her response]  
**Considering your current health condition and treatment plan, how long do you think you are likely to live?**

<input type="checkbox"/> 1	Less than 1 year
<input type="checkbox"/> 2	1 up to 2 years
<input type="checkbox"/> 3	2 up to 3 years
<input type="checkbox"/> 4	3 up to 5 years
<input type="checkbox"/> 5	5 up to 7 years
<input type="checkbox"/> 6	7 up to 10 years
<input type="checkbox"/> 7	More than 10 years, please specify _____



<b>E10</b>	<b>Some people have a strong preference concerning where they would like to spend their last days prior to death. If you had a chance, where would you like to be during the last days of your life?</b>	
	<input type="checkbox"/> 1	At my home
	<input type="checkbox"/> 2	In the home of a friend/family member
	<input type="checkbox"/> 3	In the hospital where I have been receiving medical care
	<input type="checkbox"/> 4	Hospice
	<input type="checkbox"/> 5	Nursing home
	<input type="checkbox"/> 6	Any other place, please specify: _____
	<input type="checkbox"/> 7	Doesn't matter
<b>E11<sup>7</sup></b>	<b>Do you ever wish that your life would end sooner?</b>	
	<input type="checkbox"/> 1	Yes
	<input type="checkbox"/> 2	No
	<input type="checkbox"/> 3	Not sure

<sup>7</sup> From the Desire for Death Rating Scale. Chochinov HM, Wilson KG, Enns M, Mowchun N, Lander S, Levitt M, Clinch JJ: Desire for death in the terminally ill. Am J Psychiatry 1995; 152:1185–1191.

**SECTION F: SELF BLAME AND SOCIAL STIGMA**

<b>F1<sup>6</sup> Have you smoked at least 100 times in your life?</b>		
<input type="checkbox"/> 1	Yes	<b>Answer Qs. F1.1 &amp; F1.2</b>
<input type="checkbox"/> 2	No	<b>Skip to Qs. F2</b>
<input type="checkbox"/> 3	Don't know	
<b>How old were you when you started to smoke regularly?</b>		
<b>F1.1</b> 6	<input type="text"/> years old	
<b>F1.2 Are you currently smoking?</b>		
<input type="checkbox"/> 1	<b>Yes</b>	
<input type="checkbox"/> 2	<b>No</b>	
<b>F2 Have you ever chewed betel nut/tobacco regularly?</b>		
<input type="checkbox"/> 1	Yes, I currently chew betel nut/tobacco regularly	
<input type="checkbox"/> 2	Yes, I have chewed betel nut/tobacco in the past but not anymore	
<input type="checkbox"/> 3	No	
<b>F2.1 (If F2= 1 or 2) How old were you when you started to chew betel nut/tobacco regularly?</b>		
	<input type="text"/> years old	
<b>F3<sup>6</sup> Before you were diagnosed with cancer, how often did you drink any type of alcoholic beverage?</b>		
<input type="checkbox"/> 1	Less than once a month	
<input type="checkbox"/> 2	A few times a month	
<input type="checkbox"/> 3	A few times a week	
<input type="checkbox"/> 4	Daily	
<b>F3.1 (If F3≠1) Before you were diagnosed with cancer, how much alcohol did you usually have each time you had drinks?</b>		
<input type="checkbox"/> 1	1 – 2 drinks	
<input type="checkbox"/> 2	3 – 4 drinks	
<input type="checkbox"/> 3	5 or more drinks	
<b>F3.2 Are you currently consuming any alcoholic beverages?</b>		
<input type="checkbox"/> 1	Yes	<input type="checkbox"/> 2 No

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**F4** *We have found that some people blame themselves for their cancer and some people don't blame themselves at all.*  
**How much do you blame yourself for:**

		<b>Not at all (1)</b>	<b>Somewhat (2)</b>	<b>Very much (3)</b>	<b>Completely (4)</b>
i.	Any behaviour that may have led to your cancer?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ii.	The kind of person you are (e.g., being the unlucky person who has things like cancer happen to them)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**F5** **To the extent of your knowledge, which of the following (if any) are reasons for the type of illness you have? Check all that apply.**

1	Smoking	<input type="checkbox"/>
2	Chewing betel nut/tobacco	<input type="checkbox"/>
3	Consumption of alcohol	<input type="checkbox"/>
4	Being overweight	<input type="checkbox"/>
5	Stress/ Anxiety	<input type="checkbox"/>
6	Previous bad deeds	<input type="checkbox"/>
7	God's will	<input type="checkbox"/>
8	Old age	<input type="checkbox"/>
9	Others, please specify _____	

**F6<sup>8</sup>** **We have found that some people feel differently about themselves and experience changes in their social interactions due to their cancer. Consider the statements below and indicate how often they happen for you.**

		<b>Never (1)</b>	<b>Rarely (2)</b>	<b>Sometimes (3)</b>	<b>Often (4)</b>	<b>Always (5)</b>
i.	I feel others consider me responsible for my cancer.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ii.	I am embarrassed when I tell people my diagnosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
iii.	I feel ashamed for having developed cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
iv.	People avoid me because of my cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
v.	I have an urge to keep my cancer a secret	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
vi.	I sense that others feel strained when they are around me.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

<sup>8</sup> Item is from the Shame Stigma Scale. Kissane DW, Patel SG, Baser RE, Bell R, Farberov M, Ostroff JS, et al. Preliminary evaluation of the reliability and validity of the shame and stigma scale in head and neck cancer. Head Neck. 2013;35:172-83.

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<b>F7</b>		<b>Do you think your family and friends think cancer is contagious?</b>			
<input type="checkbox"/> 1	Yes, most of them	<input type="checkbox"/> 3	No		
<input type="checkbox"/> 2	Yes, some of them	<input type="checkbox"/> 4	Not sure		
<b>F8</b>		<b>How much control do you believe you personally have over:</b>			
		<b>Absolutely no control (1)</b>	<b>Little bit of control (2)</b>	<b>Some control (3)</b>	<b>Total Control (4)</b>
i.	The stress from your illness?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ii.	Physical symptoms of your disease or side effects of your treatment (e.g., pain)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
iii.	The type of medical treatment you receive?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
iv.	Whether your condition will get better?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>F9</b>		<b>Do you believe God will cure your illness one day?</b>			
<input type="checkbox"/> 1	Yes				
<input type="checkbox"/> 2	No				
<input type="checkbox"/> 3	Not sure				
<b>F9.1</b>		<b>[If F9=Yes] How will this happen?</b>			
<input type="checkbox"/> 1	Through a miracle without medical treatment				
<input type="checkbox"/> 2	Through medical treatment				

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**SECTION G: USE OF/INTEREST IN USING MENTAL HEALTH SERVICES**

Refuse to answer

<b>G1 Have you seen any of the mental health care workers listed below as part of your cancer treatment? Check all that apply.</b>			
<input type="checkbox"/> 1	Psychiatrist	<b>Answer Qs. G2 to G4</b>	
<input type="checkbox"/> 2	Psychologist		
<input type="checkbox"/> 3	Medical social worker (for psychological support)		
<input type="checkbox"/> 4	Community counsellor		
<input type="checkbox"/> 5	Others, please specify _____		
<input type="checkbox"/> 6	Don't know	<b>Skip to Q. G5</b>	
<input type="checkbox"/> 7	No		
<b>G2 [If G1= 1 to 5] What type of mental health service did you receive?</b>			
<input type="checkbox"/> 1	Medications	<input type="checkbox"/> 3	Support group
<input type="checkbox"/> 2	Therapy/counselling	<input type="checkbox"/> 4	Other, please specify: _____
<b>G3 [If G1= 1 to 5] Where did you receive mental health services?</b>			
<input type="checkbox"/> 1	At the hospital as part of inpatient treatment		
<input type="checkbox"/> 2	At the hospital in an outpatient appointment		
<input type="checkbox"/> 3	I found a mental health professional myself		
<input type="checkbox"/> 4	As part of homecare service		
<b>G4 [If G1= 1 to 5] How helpful did you find receiving mental health services?</b>			
<input type="checkbox"/> 1	Very helpful	<input type="checkbox"/> 3	I am not sure
<input type="checkbox"/> 2	Quite helpful	<input type="checkbox"/> 4	Not helpful at all
<b>G5 [If G1= 6 or 7] Would you use mental health services if you were referred?</b>			
<input type="checkbox"/> 1	Yes		
<input type="checkbox"/> 2	No		
<input type="checkbox"/> 3	Not sure		
<b>G6 Did you delay medical treatment for cancer for any reason?</b>			
<input type="checkbox"/> 1	Yes, I delayed my medical treatment for some time	<b>Answer Q. G6.1</b>	
<input type="checkbox"/> 2	No, I sought medical treatment immediately	<b>Skip to Section H</b>	

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<b>G6.1 [If G6=1] What were the reasons for delay in your treatment? Check all that apply.</b>	
<input type="checkbox"/> 1	Trouble in identifying a suitable treatment plan
<input type="checkbox"/> 2	Cost of treatment
<input type="checkbox"/> 3	Using alternative methods of healing before medical treatment (e.g., herbal treatment, prayer, homeopathy, diet therapy)
<input type="checkbox"/> 4	I felt overwhelmed/confused and did not know what to do
<input type="checkbox"/> 5	I felt ashamed to get help for my illness
<input type="checkbox"/> 6	My family did not think that I need medical treatment
<input type="checkbox"/> 7	Other reasons, please specify _____

**SECTION H: USE OF COMPLEMENTARY AND ALTERNATIVE THERAPY**

*Complementary and Alternative Therapies refer to treatments that are used either (1) together with medical treatment, or (2) instead of medical treatment. Examples include herbal treatment, diet therapy, exercise (e.g., qi gong, yoga) and spiritual healing.*

<b>H1<sup>6</sup> Since diagnosis of cancer, what type of complementary and alternative therapy have you used? Check all that apply.</b>	
<input type="checkbox"/> 1	Traditional Chinese Medicine
<input type="checkbox"/> 2	Traditional Indian Medicine (e.g., Ayurveda, unani, siddha)
<input type="checkbox"/> 3	Homeopathy
<input type="checkbox"/> 4	Western herbal/health supplements
<input type="checkbox"/> 5	Others, please specify _____
<input type="checkbox"/> 6	None of above
<input type="checkbox"/> 8	Traditional Vietnamese Medicine

<b>H2<sup>6</sup> Have you used any of the therapies listed below for your cancer? Check all that apply.</b>		
<input type="checkbox"/> 1	Herbal medicine to consume	<b>Answer Qs. H2.1 to H2.6</b>
<input type="checkbox"/> 2	Diet therapy (e.g., macrobiotic diet)	
<input type="checkbox"/> 3	Acupuncture/ acupressure/ moxibustion	
<input type="checkbox"/> 4	Massage/ Reflexology	
<input type="checkbox"/> 5	Exercise (e.g., qi gong, tai chi, yoga)	
<input type="checkbox"/> 6	Spiritual/faith healing by others	
<input type="checkbox"/> 7	Others, please describe _____	
<input type="checkbox"/> 8	None of above	<b>Skip to next section</b>

<b>H2.1 [If H2=1 to 7] When did you start using this therapy for cancer?</b>	
<input type="checkbox"/> 1	Before being treated in the hospital



	<input type="checkbox"/> 2	While I was being treated in the hospital	
	<input type="checkbox"/> 3	After being treated in the hospital	
<b>H2.2</b>	<b>[If H2=1 to 7] Is the therapy meant to replace your medical treatment?</b>		
	<input type="checkbox"/> 1	Yes	<input type="checkbox"/> 2    No
<b>H2.3<sup>6</sup></b>	<b>[If H2=1 to 7] Did you tell your doctor that you are using this therapy for your cancer?</b>		
	<input type="checkbox"/> 1	Yes	
	<input type="checkbox"/> 2	No	
<b>H2.3.1</b>	<b>[If H2.3=1] How supportive was your doctor of this therapy?</b>		
	<input type="checkbox"/> 1	Supportive	<input type="checkbox"/> 3    Neutral
	<input type="checkbox"/> 2	Not supportive	<input type="checkbox"/> 4    Don't know
<b>H2.4<sup>6</sup></b>	<b>[If H2=1 to 7] What is the main reason for using this therapy?</b>		
	<input type="checkbox"/> 1	To boost my immune system	
	<input type="checkbox"/> 2	To reduce side effects of treatment	
	<input type="checkbox"/> 3	To control my symptoms (e.g. pain). If so, describe the symptom _____	
	<input type="checkbox"/> 4	To prolong life	
	<input type="checkbox"/> 5	To cure my illness	
	<input type="checkbox"/> 6	Others. Please describe _____	
<b>H2.5</b>	<b>[If H2=1 to 7] How long have you been using this therapy?</b>		
	<input type="checkbox"/> 1	Less than 1 month	
	<input type="checkbox"/> 2	Between 1 to 3 months	
	<input type="checkbox"/> 3	Between 3 to 6 months	
	<input type="checkbox"/> 4	More than 6 months	
	<input type="checkbox"/> 5	I am no longer using this therapy	
<b>H2.6<sup>6</sup></b>	<b>[If H2=1 to 7] Roughly how much did you spend, in total, on complementary and alternative therapies in the last 3 months?</b>		
	_____		

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**SECTION I: DEMOGRAPHICS**

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<b>I1 What is your current occupation?</b>			
<input type="checkbox"/> 1	Farmer	<input type="checkbox"/> 6	Service- Government
<input type="checkbox"/> 2	Wage labourer	<input type="checkbox"/> 7	Homemaker
<input type="checkbox"/> 3	Skilled worker	<input type="checkbox"/> 8	Retired
<input type="checkbox"/> 4	Shop keeper	<input type="checkbox"/> 9	Unemployed
<input type="checkbox"/> 5	Self-employed	<input type="checkbox"/> 10	Others, please specify _____
<b>I2 Were you working before you were seeking care at this hospital, for your illness?</b>			
<input type="checkbox"/> 1	Working full-time	<input type="checkbox"/> 4	Homemaker
<input type="checkbox"/> 2	Working part-time	<input type="checkbox"/> 5	Unemployed
<input type="checkbox"/> 3	Retired and not working		
<b>I3 How many persons live in your household?</b>			
<input type="text"/>		Number of people	
<b>I4 How would you rate the economic status of your household?</b>			
<input type="checkbox"/> 1	Poor	<input type="checkbox"/> 3	Upper Middle Class
<input type="checkbox"/> 2	Lower Middle Class	<input type="checkbox"/> 4	Wealthy

**Thank you for completing the survey.**

**POST INTERVIEW: OBSERVATIONS OF THE INTERVIEWER**

[Interviewer: Please fill in the following questions based on your observations during the interview.]

<b>INT1 During the survey, was there someone either present in the room or in a room nearby who could hear the contents of the interview?</b>						
<input type="checkbox"/> 1	Yes, during most of the interview					
<input type="checkbox"/> 2	Yes, during half of the interview					
<input type="checkbox"/> 3	Yes, at times during the interview					
<input type="checkbox"/> 4	For the most part, no other person was present to hear					
<b>INT2 To what extent did this person influence the patient's responses?</b>						
<input type="checkbox"/> 1	Would correct the patient's responses or prevent the patient from giving his or her own responses					
<input type="checkbox"/> 2	Listened to the interview, but did not interrupt verbally					
<input type="checkbox"/> 3	Hardly paid any attention to the interview					
<input type="checkbox"/> 4	Didn't seem to have any effect on the patient's responses					
<b>INT3 The following concerns your impression of the patient.</b>						
		<b>Yes (1)</b>	<b>Some what (2)</b>	<b>Not really (3)</b>	<b>No (4)</b>	<b>Not sure (5)</b>
i.	Did you feel that the patient was mentally competent enough to provide adequate responses?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ii.	Did you feel that the patient understood the questions?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
iii.	Did you feel that the patient was responsive to the interview?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
iv.	Did you feel the patient's hearing/visual difficulties adversely affected the survey?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>INT4 How tired did the patient appear after the interview?</b>						
<input type="checkbox"/> 1	Very					
<input type="checkbox"/> 2	Somewhat					
<input type="checkbox"/> 3	Not at all					