

Non-hospitalized (circle): Baseline 7 days 1 month 3 months 6 months. 12 months
 Hospitalized non-ICU (circle): Admission 7 days/discharge 1 month 3 months 6 months 12 months
 Hospitalized ICU (circle): ICU Stay 7 days post-ICU discharge 1 month post-ICU discharge
 3 months post-ICU discharge 6 months post-ICU discharge 12 months post-ICU discharge

Form P-2: SARC-F Screen for Sarcopenia (SARC-F)

Baseline: Please answer the questionnaire thinking about your health prior to your COVID-19 diagnosis/illness.
 Follow-up: Please answer the questionnaire thinking about your current health.

SARC-F Screen for Sarcopenia (Loss of Muscle)		
Component	Question	Scoring
Strength	How much difficulty do you have in lifting and carrying 10 pounds?	<input type="checkbox"/> None <input type="checkbox"/> Some <input type="checkbox"/> A lot or unable
Assistance in Walking	How much difficulty do you have walking across a room?	<input type="checkbox"/> None <input type="checkbox"/> Some <input type="checkbox"/> A Lot, use aids or unable
Rise from a Chair	How much difficulty do you have transferring from a chair or bed?	<input type="checkbox"/> None <input type="checkbox"/> Some <input type="checkbox"/> A lot or unable without help
Climb stairs	How much difficulty do you have climbing a flight of ten stairs?	<input type="checkbox"/> None <input type="checkbox"/> Some <input type="checkbox"/> A lot or unable
Falls	How many times have you fallen in the last year?	<input type="checkbox"/> None <input type="checkbox"/> 1-3 falls <input type="checkbox"/> 4 or more falls
From MalmstromTK, Morley JE. J Frailty and Aging 2013;2:55-6.		

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		3 months post-ICU discharge	6 months post-ICU discharge	12 months post-ICU discharge		

Form P-3: Simplified Nutritional Assessment Questionnaire (SNAQ)

Baseline: Please answer the questionnaire thinking about your health prior to your COVID-19 diagnosis/illness.
 Follow-up: Please answer the questionnaire thinking about your current health.

The SNAQ (Simplified Nutritional Assessment Questionnaire)	
My appetite is	a. very poor <input type="checkbox"/> b. poor <input type="checkbox"/> c. average <input type="checkbox"/> d. good <input type="checkbox"/> e. very good <input type="checkbox"/>
Food tastes	a. very bad <input type="checkbox"/> b. bad <input type="checkbox"/> c. average <input type="checkbox"/> d. good <input type="checkbox"/> e. very good <input type="checkbox"/>
When I eat	a. I feel full after eating only a few mouthfuls <input type="checkbox"/> b. I feel full after eating about a third of a meal <input type="checkbox"/> c. I feel full after eating over half a meal <input type="checkbox"/> d. I feel full after eating most of the meal <input type="checkbox"/> e. I hardly ever feel full <input type="checkbox"/>
Normally I eat	a. Less than one meal a day <input type="checkbox"/> b. One meal a day <input type="checkbox"/> c. Two meals a day <input type="checkbox"/> d. Three meals a day <input type="checkbox"/> e. More than three meals a day <input type="checkbox"/>
From Wilson et al. Am J Clin Nutr 2005;82:1074-81.	

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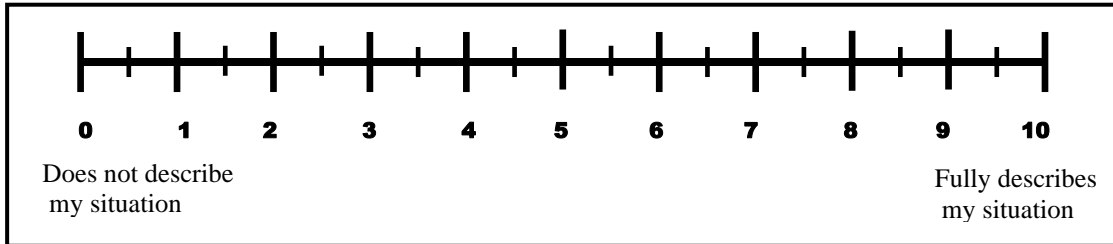
Hospitalized ICU (circle): ICU Stay 7 days post-ICU discharge 1 month post-ICU discharge

3 months post-ICU discharge 6 months post-ICU discharge 12 months post-ICU discharge

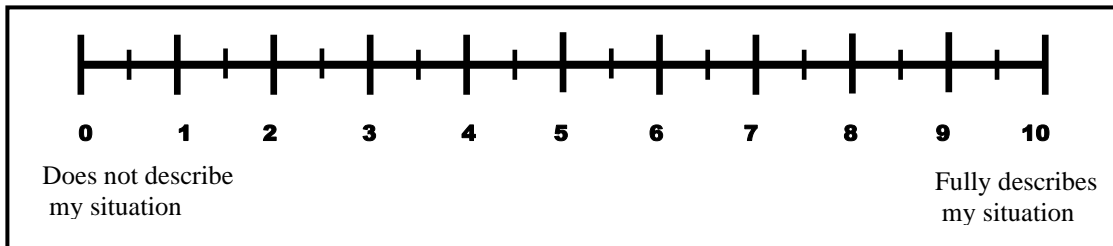
Form P-4: Reintegration to Normal Living Index (RNLI)

Please circle the response that best fits your normal personal situation today.

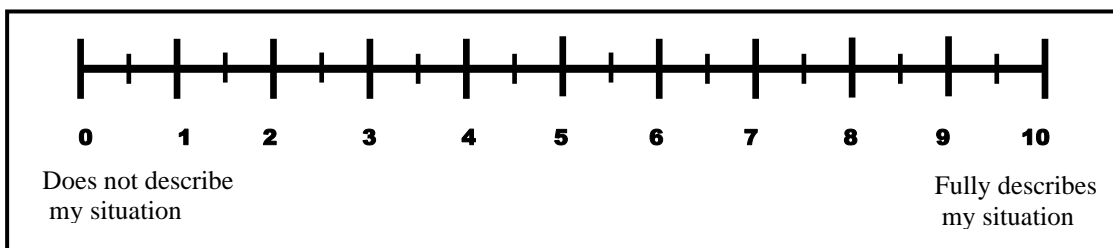
(1) I move around my living quarters as I feel necessary.



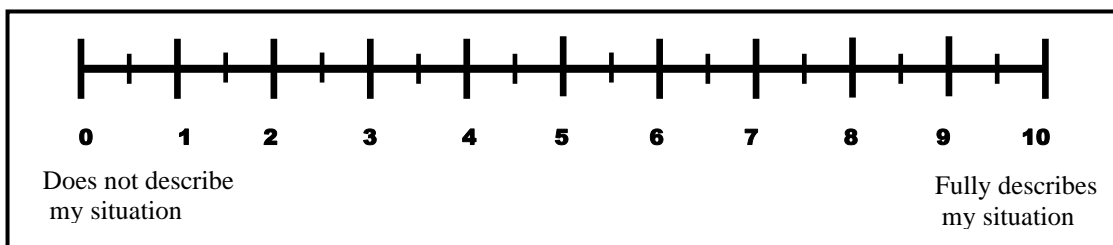
(2) I move around my community as I feel necessary.



(3) I am able to take trips out of town as I feel are necessary.

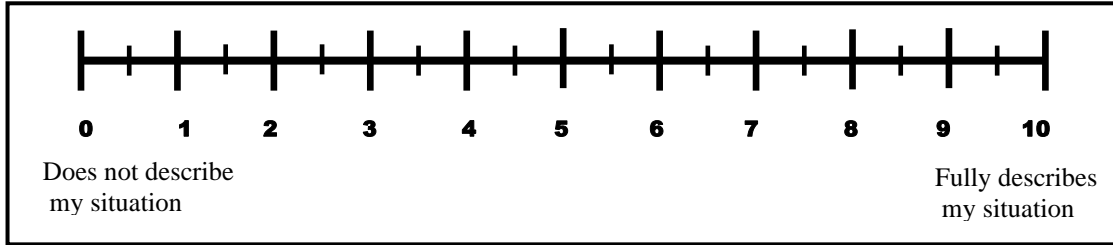


(4) I am comfortable with how my self-care needs (dressing, feeding, toileting, bathing) are met.

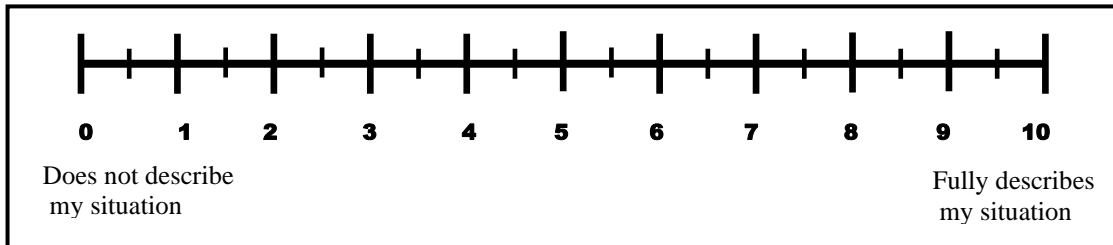


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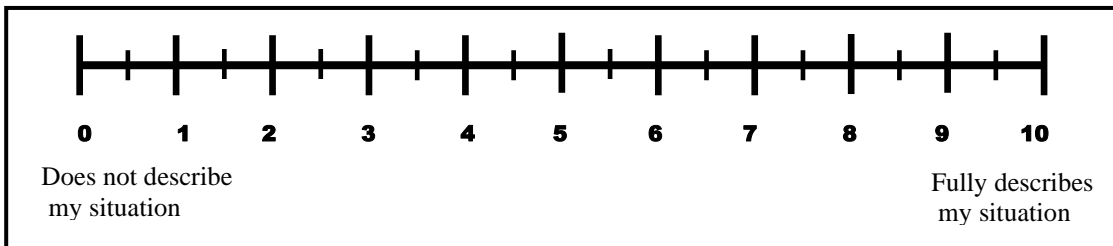
(5) I spend most of my days occupied in work activity that is necessary or important to me.



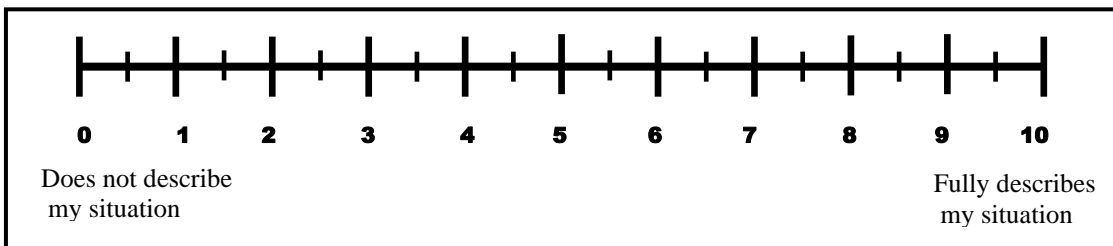
(6) I am able to participate in recreational activities (hobbies, crafts, sports, reading, television, games, computers etc.) as I want to.



(7) I participate in social activities with family, friends and/or business acquaintances as is necessary or desirable to me.

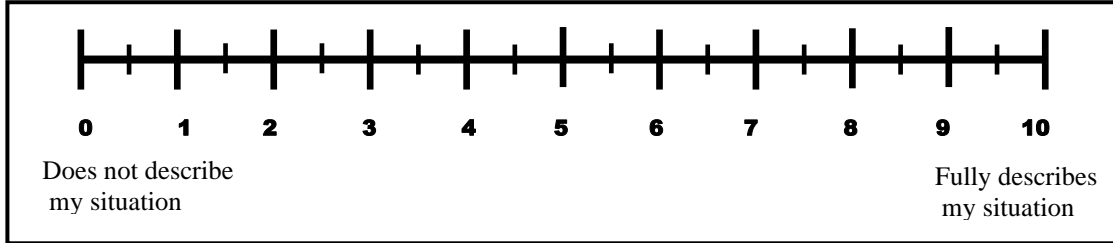


(8) I assume a role in my family which meets my needs and those of other family members.

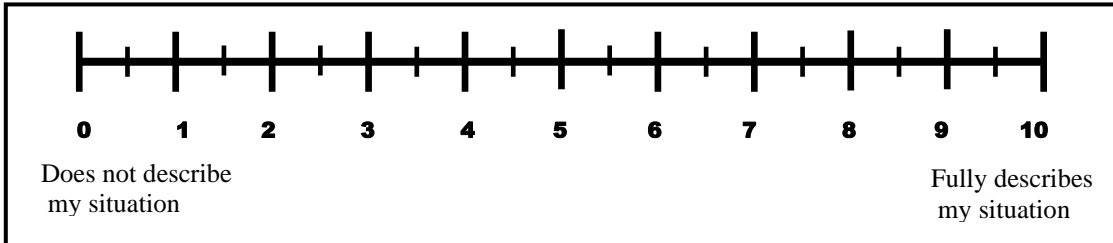


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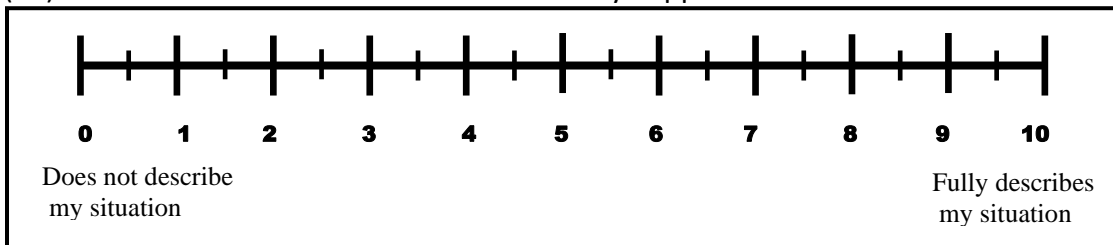
(9) In general I am comfortable with my personal relationships.



(10) In general I am comfortable with myself when I am in the company of others.



(11) I feel that I can deal with life events as they happen.



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3 months post-ICU discharge 6 months post-ICU discharge 12 months post-ICU discharge

those outside their family that they had COVID-19	4. Disagree	5. Strongly Disagree
Some people who had COVID-19 are afraid of going to COVID-19 clinics because other people may see them there	1. Strongly agree 4. Disagree	2. Agree 5. Strongly Disagree
Some people who had COVID-19 feel guilty because their family had the burden of caring for them	1. Strongly agree 4. Disagree	2. Agree 5. Strongly Disagree
Some people who had COVID-19 will choose carefully who they tell about having had COVID-19	1. Strongly agree 4. Disagree	2. Agree 5. Strongly Disagree
Some people who had COVID-19 feel guilty for getting COVID-19	1. Strongly agree 4. Disagree	2. Agree 5. Strongly Disagree
Some people who had COVID-19 are afraid to tell their family that they had COVID-19	1. Strongly agree 4. Disagree	2. Agree 5. Strongly Disagree

Modified from: Van Rie A et al. Trop Med Int Health 2008; 13(1):21-30

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Instructions for Completing the Questionnaire

Please read each question carefully and answer every question below. Some of the questions are similar but they are not the same.

1. In general, would you say your health is:

- 1 - Excellent
- 2 - Very good
- 3 - Good
- 4 - Fair
- 5 - Poor

2. Compared to one year ago, how would you rate your health in general now?

- 1 - Much better now than one year ago
- 2 - Somewhat better now than one year ago
- 3 - About the same
- 4 - Somewhat worse now than one year ago
- 5 - Much worse now than one year ago

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The following items are about activities you might do during a typical day. Does **your health now limit you** in these activities? If so, how much?

	Yes, limited a lot	Yes, limited a little	No, not limited at all
3. Vigorous activities , such as running, lifting heavy objects, participating in strenuous sports	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
4. Moderate activities , such as moving a table, pushing a vacuum cleaner, bowling, or playing golf	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
5. Lifting or carrying groceries	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
6. Climbing several flights of stairs	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
7. Climbing one flight of stairs	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
8. Bending, kneeling, or stooping	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
9. Walking more than a mile	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
10. Walking several blocks	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
11. Walking one block	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3
12. Bathing or dressing yourself	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3

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During the **past 4 weeks**, have you had any of the following problems with your work or other regular daily activities **as a result of your physical health?**

- | | Yes | No |
|---|-----------------------|-----------------------|
| 13. Cut down the amount of time you spent on work or other activities | <input type="radio"/> | <input type="radio"/> |
| | 1 | 2 |
| 14. Accomplished less than you would like | <input type="radio"/> | <input type="radio"/> |
| | 1 | 2 |
| 15. Were limited in the kind of work or other activities | <input type="radio"/> | <input type="radio"/> |
| | 1 | 2 |
| 16. Had difficulty performing the work or other activities (for example, it took extra effort) | <input type="radio"/> | <input type="radio"/> |
| | 1 | 2 |

During the **past 4 weeks**, have you had any of the following problems with your work or other regular daily activities **as a result of any emotional problems** (such as feeling depressed or anxious)?

- | | Yes | No |
|--|-------------------------|-------------------------|
| 17. Cut down the amount of time you spent on work or other activities | <input type="radio"/> 1 | <input type="radio"/> 2 |
| 18. Accomplished less than you would like | <input type="radio"/> 1 | <input type="radio"/> 2 |
| 19. Didn't do work or other activities as carefully as usual | <input type="radio"/> 1 | <input type="radio"/> 2 |

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20. During the **past 4 weeks**, to what extent has your physical health or emotional problems interfered with your normal social activities with family, friends, neighbors, or groups?

- 1 - Not at all
- 2 - Slightly
- 3 - Moderately
- 4 - Quite a bit
- 5 - Extremely

21. How much **bodily** pain have you had during the **past 4 weeks**?

- 1 - None
- 2 - Very mild
- 3 - Mild
- 4 - Moderate
- 5 - Severe
- 6 - Very severe

22. During the **past 4 weeks**, how much did **pain** interfere with your normal work (including both work outside the home and housework)?

- 1 - Not at all
- 2 - A little bit
- 3 - Moderately
- 4 - Quite a bit
- 5 - Extremely

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These questions are about how you feel and how things have been with you **during the past 4 weeks**. For each question, please give the one answer that comes closest to the way you have been feeling.

How much of the time during the **past 4 weeks**...

	All of the time	Most of the time	A good bit of the time	Some of the time	A little of the time	None of the time
23. Did you feel full of pep?	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5	<input type="radio"/> 6
24. Have you been a very nervous person?	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5	<input type="radio"/> 6
25. Have you felt so down in the dumps that nothing could cheer you up?	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5	<input type="radio"/> 6
26. Have you felt calm and peaceful?	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5	<input type="radio"/> 6
27. Did you have a lot of energy?	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5	<input type="radio"/> 6
28. Have you felt downhearted and blue?	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5	<input type="radio"/> 6
29. Did you feel worn out?	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5	<input type="radio"/> 6
30. Have you been a happy person?	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5	<input type="radio"/> 6
31. Did you feel tired?	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5	<input type="radio"/> 6

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32. During the **past 4 weeks**, how much of the time has **your physical health or emotional problems** interfered with your social activities (like visiting with friends, relatives, etc.)?

- 1 - All of the time
- 2 - Most of the time
- 3 - Some of the time
- 4 - A little of the time
- 5 - None of the time

How TRUE or FALSE is **each** of the following statements for you.

	Definitely true	Mostly true	Don't know	Mostly false	Definitely false
33. I seem to get sick a little easier than other people	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
34. I am as healthy as anybody I know	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
35. I expect my health to get worse	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
36. My health is excellent	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5

ABOUT

The RAND Corporation is a research organization that develops solutions to public policy challenges to help make communities throughout the world safer and more secure, healthier and more prosperous. RAND is nonprofit, nonpartisan, and committed to the public interest.

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Form P-7: Connor-Davidson Resilience Scale (CD-RISC SCALE)

DIRECTIONS: Please respond to each statement with reference to the previous month, understanding that if a particular situation has not arisen in this time, then the response should be determined by how you think you would have reacted. ***NOTE: CD-2 is completed by responding to questions 1 and 5.**

		Not True At All	Rarely True	Sometimes True	Often True	True Nearly All the Time
1.	I am able to adapt when changes occur.	0	1	2	3	4
2.	I can deal with whatever comes my way.	0	1	2	3	4
3.	I try to see the humorous side of things when I am faced with problems.	0	1	2	3	4
4.	Having to cope with stress can make me stronger.	0	1	2	3	4
5.	I tend to bounce back after illness, injury or other hardships.	0	1	2	3	4
6.	I believe I can achieve my goals, even if there are obstacles.	0	1	2	3	4
7.	Under pressure, I stay focused and think clearly.	0	1	2	3	4
8.	I am not easily discouraged by failure.	0	1	2	3	4
9.	I think of myself as a strong person when dealing with life's challenges and difficulties.	0	1	2	3	4
10.	I am able to handle unpleasant or painful feelings like sadness, fear, and anger.	0	1	2	3	4

Campbell-Sills L, Stein MB. Psychometric analysis and refinement of the Connor-Davidson Resilience Scale (CD-RISC): validation of a 10-item measure of resilience. J Traumatic Stress 2007; 20: 1019-102

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Form P-8: Post-traumatic Stress Disorder Checklist (PCL-5)

Instructions: Below is a list of problems that people sometimes have in response to a very stressful experience. Please read each problem carefully and then circle one of the numbers to the right to indicate how much you have been bothered by that problem in the past month.

In the past month, how much were you bothered by:	Not at all	A little bit	Moderately	Quite a bit	Extremely
1. Repeated, disturbing, and unwanted memories of the stressful experience?	0	1	2	3	4
2. Repeated, disturbing dreams of the stressful experience?	0	1	2	3	4
3. Suddenly feeling or acting as if the stressful experience were actually happening again (as if you were actually back there reliving it)?	0	1	2	3	4
4. Feeling very upset when something reminded you of the stressful experience?	0	1	2	3	4
5. Having strong physical reactions when something reminded you of the stressful experience (for example, heart pounding, trouble breathing, sweating)?	0	1	2	3	4
6. Avoiding memories, thoughts, or feelings related to the stressful experience?	0	1	2	3	4
7. Avoiding external reminders of the stressful experience (for example, people, places, conversations, activities, objects, or situations)?	0	1	2	3	4
8. Trouble remembering important parts of the stressful experience?	0	1	2	3	4
9. Having strong negative beliefs about yourself, other people, or the world (for example, having thoughts such as: I am bad, there is something seriously wrong with me, no one can be trusted, the world is completely dangerous)?	0	1	2	3	4
10. Blaming yourself or someone else for the stressful experience or what happened after it?	0	1	2	3	4
11. Having strong negative feelings such as fear, horror, anger, guilt, or shame?	0	1	2	3	4
12. Loss of interest in activities that you used to enjoy?	0	1	2	3	4
13. Feeling distant or cut off from other people?	0	1	2	3	4
14. Trouble experiencing positive feelings (for example, being unable to feel happiness or have loving feelings for people close to you)?	0	1	2	3	4
15. Irritable behavior, angry outbursts, or acting aggressively?	0	1	2	3	4
16. Taking too many risks or doing things that could cause you harm?	0	1	2	3	4
17. Being "superalert" or watchful or on guard?	0	1	2	3	4
18. Feeling jumpy or easily startled?	0	1	2	3	4
19. Having difficulty concentrating?	0	1	2	3	4
20. Trouble falling or staying asleep?	0	1	2	3	4

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Form P-9: Patient Health Questionnaire (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? Please circle the number to the right to indicate your response.	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

For office coding: Total Score _____ = _____ + _____ + _____

Total Score _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all Somewhat difficult Very difficult Extremely difficult

Kroenke K, Spitzer RL, Williams JB. The PHQ-9: Validity of a brief depression severity measure. J Gen Intern Med. 2001;16(9):606-613.

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Form P-10 General Anxiety Disorder (GAD-7)

1. Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all	Several days	Over half the days	Nearly every day
• Feeling nervous, anxious, or on edge	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
• Not being able to stop or control worrying	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
• Worrying too much about different things	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
• Trouble relaxing	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
• Being so restless that it's hard to sit still	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
• Becoming easily annoyed or irritable	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
• Feeling afraid as if something awful might happen	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
<i>Add the score for each column</i>				
TOTAL SCORE (add your column scores)				
	Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
2. If you checked off any problem on this questionnaire so far, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3

GAD-7 developed by Dr. Robert L. Spitzer, Dr. K. Kroenke. et.al

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Hospitalized non-ICU:	Admission.	7 days/discharge.	1 month	3 months	6 months	12 months
Hospitalized ICU:	ICU Stay	7 days.	1 month	3 months	6 months	12 months

Form P-11: Post-discharge Questionnaire

Post-discharge instructions	Did you receive enough information from hospital staff about what to do if you were worried about your condition or treatment after you left the hospital?	1. Completely <input type="checkbox"/> 2. Quite a bit <input type="checkbox"/> 3. Partly <input type="checkbox"/> 4. Not at all <input type="checkbox"/>
Post-discharge instructions	During your hospital stay, did doctors, nurses or other hospital staff talk with you about whether you would have the help you needed when you left the hospital?	1. Yes <input type="checkbox"/> 2. No <input type="checkbox"/> 3. Prefer not to answer <input type="checkbox"/>
Post-discharge instructions	Before you left the hospital, did you have a clear understanding about all of your prescribed medications, including those you were taking before your hospital stay?	1. Completely <input type="checkbox"/> 2. Quite a bit <input type="checkbox"/> 3. Partly <input type="checkbox"/> 4. Not at all <input type="checkbox"/> 5. Not applicable <input type="checkbox"/>
Post-discharge instructions	During your hospital stay, did you get information in writing about what symptoms or health problems to look out for after you left the hospital?	1. Yes <input type="checkbox"/> 2. No <input type="checkbox"/> 3. Prefer not to answer <input type="checkbox"/>
Post-discharge instructions	When you left the hospital, did you have a clear understanding about your follow-up appointments and investigations?	1. Strongly Agree <input type="checkbox"/> 2. Agree <input type="checkbox"/> 3. Disagree <input type="checkbox"/> 4. Strongly Disagree <input type="checkbox"/>
Post-discharge instructions	When you left the hospital, did you have a better understanding of your condition than when you entered?	1. Completely <input type="checkbox"/> 2. Quite a bit <input type="checkbox"/> 3. Partly <input type="checkbox"/> 4. Not at all <input type="checkbox"/>
Post-discharge health care utilization	Have you gone to the Emergency Room in the last 30 days?	1. Yes <input type="checkbox"/> 2. No <input type="checkbox"/>
Home care	Did you receive home care following discharge from hospital?	1. Yes <input type="checkbox"/> 2. No <input type="checkbox"/> 3. Prefer not to answer <input type="checkbox"/>
Home care	Did your home care start when you needed it?	1. Yes <input type="checkbox"/> 2. No <input type="checkbox"/> 3. Don't know/don't remember <input type="checkbox"/> 4. Prefer not to answer <input type="checkbox"/>
Caregivers	How has your family helped since you left hospital?	1. Self-care <input type="checkbox"/> 2. Meal preparation/cooking <input type="checkbox"/> 3. Shopping <input type="checkbox"/> 4. Medication administration <input type="checkbox"/> 5. Transportation <input type="checkbox"/> 6. Appointments with doctors <input type="checkbox"/> 7. Banking/Finances <input type="checkbox"/>

Non-hospitalized:	Baseline.	7 days.	1 month	3 month	6 months	12 months
Hospitalized non-ICU:	Admission.	7 days/discharge.	1 month	3 months	6 months	12 months
Hospitalized ICU:	ICU Stay	7 days.	1 month	3 months	6 months	12 months

		8. Household chores (e.g. cleaning, laundry) <input type="checkbox"/> 9. Other <input type="checkbox"/>
Caregivers	Is this a change from before your recent hospitalization?	1. Yes <input type="checkbox"/> 2. No <input type="checkbox"/> 3. Prefer not to answer <input type="checkbox"/> If yes: How? _____ _____ _____