University of Nottingham & Nottingham
Respiratory Biomedical Research Unit

SPARC *

We would like to know a bit more about you and your concerns.

Please fill in this questionnaire (with help from a relative or carer if needed) and return it to one of our team.

There are no "right" or "wrong" answers. If you are unsure of a question, please leave it blank.

THANK YOU

* Sheffield Profile for Assessment and Referral to Care

Your initials:……. Date completed:...../……./…….

COMMUNICATION AND INFORMATION ISSUES

1. Have you been able to talk to any of the following people about your condition?	Yes	No
a. Your doctor	☐	☐
b. Community nurse	☐	☐
c. Hospital nurse	☐	☐
d. Religious advisor	☐	☐
e. Social worker	☐	☐
f. Family	☐	☐
g. Other people (please state): _____		

PHYSICAL SYMPTOMS

Please circle one answer per line

In the past month, have you been distressed or bothered by:		Not at all	A little bit	Quite a bit	Very much
2.	Pain?	0	1	2	3
3.	Loss of memory?	0	1	2	3
4.	Headache?	0	1	2	3
5.	Dry mouth?	0	1	2	3
6.	Sore mouth?	0	1	2	3
7.	Shortness of breath?	0	1	2	3
8.	Cough?	0	1	2	3
9.	Feeling sick (nausea)?	0	1	2	3
10.	Being sick (vomiting)?	0	1	2	3
11.	Bowel problems (e.g. constipation, diarrhoea, incontinence)?	0	1	2	3
12.	Bladder problems (urinary incontinence)?	0	1	2	3
13.	Feeling weak?	0	1	2	3
14.	Feeling tired?	0	1	2	3
15.	Problems sleeping at night?	0	1	2	3
16.	Feeling sleepy during the day?	0	1	2	3

PHYSICAL SYMPTOMS continued		Not at all	A little bit	Quite a bit	Very much
17.	Loss of appetite?	0	1	2	3
18.	Changes in your weight?	0	1	2	3
19.	Problems with swallowing?	0	1	2	3
20.	Being concerned about changes in your appearance?	0	1	2	3
21.	Feeling restless and agitated?	0	1	2	3
22.	Feeling that your symptoms are not controlled?	0	1	2	3

PSYCHOLOGICAL ISSUES		Please circle one answer per line			
In the past month, have you been distressed or bothered by:		**Not at all**	**A little bit**	**Quite a bit**	**Very much**
23.	Feeling anxious?	0	1	2	3
24.	Feeling as if you are in a low mood?	0	1	2	3
25.	Feeling confused?	0	1	2	3
26.	Feeling as if you are unable to concentrate?	0	1	2	3
27.	Feeling lonely?	0	1	2	3
28.	Feeling that everything is an effort?	0	1	2	3
29.	Feeling that life is not worth living?	0	1	2	3
30.	Thoughts about ending it all?	0	1	2	3
31.	The effect of your condition on your sexual life?	0	1	2	3

RELIGIOUS AND SPIRITUAL ISSUES		Please circle one answer per line			
In the past month, have you been distressed or bothered by:		**Not at all**	**A little bit**	**Quite a bit**	**Very much**
32.	Worrying thoughts about death or dying?	0	1	2	3
33.	Religious or spiritual needs not being met?	0	1	2	3

INDEPENDENCE AND ACTIVITY

Please circle one answer per line

In the past month, have you been distressed or bothered by:		Not at all	A little bit	Quite a bit	Very much
34.	Losing your independence?	0	1	2	3
35.	Changes in your ability to carry out your usual daily activities such as washing, bathing or going to the toilet?	0	1	2	3
36.	Changes in your ability to carry out your usual household tasks such as cooking for yourself or cleaning the house?	0	1	2	3

FAMILY AND SOCIAL ISSUES

Please circle one answer per line

In the past month, have you been distressed or bothered by:		Not at all	A little bit	Quite a bit	Very much
37.	Feeling that people do not understand what you want?	0	1	2	3
38.	Worrying about the effect that your illness is having on your family or other people?	0	1	2	3
39.	Lack of support from your family or other people?	0	1	2	3
40.	Needing more help than your family or other people could give?	0	1	2	3

TREATMENT ISSUES

Please circle one answer per line

In the past month, have you been distressed or bothered by:		Not at all	A little bit	Quite a bit	Very much
41.	Side effects from your treatment?	0	1	2	3
42.	Worrying about long term effects of your treatment?	0	1	2	3

PERSONAL ISSUES		Yes	No
43.	Do you need any help with your personal affairs?	☐	☐
44.	Would you like to talk to another professional about your condition or treatment?	☐	☐
45.	**Would you like any more information about the following?**		
	a. Your condition	☐	☐
	b. Your care	☐	☐
	c. Your treatment	☐	☐
	d. Other types of support	☐	☐
	e. Financial issues	☐	☐
	f. Other (please state): _____		

Are there any other concerns that you would like us to know about?

Carry on over the page if needed

You can use this section to jot down any questions that you want to ask your doctors or other caring professionals

Question 1

Question 2

Question 3