$\overline{}$	\neg	-	\neg	
	- 1 - 1			
-				

Keeping Children Safe: Measuring the cost of children's accidents



These questions ask about how much your child's accident cost you, your family and the NHS in the FIRST TWO WEEKS after the accident and whether your child is getting better.

Part 1. About your child's recent visit to the Accident and Emergency (A&E) Department, Minor Injuries Unit or Walk In Centre

These questions are about your child's visit to the ARF Department, Miner Injuries

	lk-In Centre after an accident, on/_/
.1 Pleas	e tell us which hospital/unit/centre you went to: (please \prec all that apply)
	Queen's Medical Centre, Nottingham
	Norfolk and Norwich University Hospital, Norwich
	Frenchay Hospital, Bristol
	Bristol Royal Hospital for Children
	Royal Victoria Infirmary, Newcastle
	Queen Bizabeth Hospital, Gateshead
	North Tyneside Hospital, North Shields
	Wansbeck Hospital, Ashington
	NHS Walk-In Centre (please give no. 1)
	Minor Injuries Unit (please (we nar. e)
	Other (please descr. e,

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ts		☐ Yes] No				
							\	
		If YES, please to when they left h	ell us the	e date when they first sta (discharge date).	yed in hospital (admi	وسيم ور او) 'a 't	ne date
		Admission date		Day Monti	Year			
		Discharge date		Day Mont				
r	1.3	Did your child In Centre or o	have an	ny of these tests in i \ mrd? (Please - one b x	A. E Depretment, Por a sch ane)	linor Inje	uries U	nit, Walk-
				10/14	Yes	No		Don't Know
_	Blood	d test						
)	Urine	e test	7					
_	X-ray	y						
	. 10	, vita sound, MRI		an)				
	r ge	r(s' (please descri	be)					
1711	1.4	Did your child Walk-In Centr		ny of these treatments the ward?		nent, Min		
					(Priests	Yes	No.	Don't
\nabla_1 \text{'}	Obse	ervation (kept in Al ked to make sure t	SE, Mino	or Injuries Unit or on ward	so child can be	res	INO	know
	Advis		THERE are	e no prociems)				
	Medi	icine given by mou	th					
	Medi	icine given by injec	tion					
	Crea	m put on their skir	n					
	Medi	cine given to take	home					
	Dres	sing for wound or l	bum					
_	Stitd	hes						
	Pape	r stitches (steri-st	rips) or	wound glue				
-	Band	lage, sling or supp	ort					

2

1.2 Did your child stay in hospital for ONE OR MORE NIGHTS because of their accident?

(Please < one box)

Splint (equipment to stop injured part of body moving)

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Manipulation of broken or fractured bone (putting bone back in line)		
Manipulation of dislocated joint (putting joint back in place)	Т	
Operation to fix broken or fractured bone using metal plate, pins or wires	\top	
Cast to hold broken or fractured bone in place (e.g. plaster, resin, fibre- glass cast)		
Physiotherapy		
Stomach wash out		
General anaesthetic (being put to sleep for an operation)		
Local anaesthetic (injection to numb part of body)		
Tetanus injection		
Drip		
Blood transfusion		
Chest drain		
Oxygen through mask or tube to help breathing		
Tube in throat for child who cannot breathe for themselves		
Resuscitation (to restart breathing or heart)		
Other(s) (please describe)		

	Yes	[No
--	-----	---	--	----

Part 2. Visits to your GP for your child's accident

2.1 In the FIRST TWO WEEKS after the accident, how many times has your child visited any of these health professionals at your <u>GP's surgery</u> because of their accident? (Please , or 10° 8 mone)

ip.	
ractice nurse	
ther (please say who)	

Part 3. Visits to other health professionals for your child's accident

3.1 In the FIRST TWO WEEKS after the accident, how many times has your child visited, or been visited at home by, one of these health professionals because of their accident? (Please put '0' if pane)

	Number of visits	Treatment site (e.g. home, clinic, name of hospital)	Dio you	
		- ()	1 2	No
Doctor / Consultant		-61		
Health visitor				
Physiotherapist				
Nurse (Don't include GP visits here)				
Other (please say who)(Don't in'e \ _'.s to Practice Nurse here)				

		_			
			7	spital AND visits to the Day Case Unit for your chil	
14.1	- EN 11	75-11	hos	spital AND visits to the Day Case Unit for your chil	d's
	4 Table 1				
TTO.	DOM:				

1	In the FIRST TWO WEEKS after the accident, has your child had to stay in hospital
	overnight or visit a day case unit because of their accident? (Please - one box)

\Box	Yes -	please	fill	in the	table	below	
--------	-------	--------	------	--------	-------	-------	--

☐ No - please go to S	ection 5

	Admission Date	Discharge Date	Name of the hospital	Name of consultant (# known)	Name of ward (if known)
Stay 1					
Stay 2					
Stay 3					
Stay 4					
Stay 5					

Par	t 5. Medicine and med	lical supplies for your child's accident	5.3				ve you GOT ANY AIDS OR MADE ANY den because of their accident? (Please <
1	In the FIRST TWO WEEKS medicines because of the	S after the accident, has your child taken any PRESCRIBED tir accident? (Please Yone box)		☐ Yes - p	lease fill in the table bel	OW	
	Yes - please fill in the	table below		☐ No - pl	ease go to Section 6		
	☐ No - please go to Section	on 5.2	Тур	e of Aid/Char	iges made (e.g. Wheel hair)	Cost of item	Who bought this or gave you this. (e.g. (yourself, family, NHS, social set to ber)
	Please list all medicines gre	scribed by a doctor or nurse because of your child's accident.		•	mair)	(if known)	(yourself, family, NYIS, Social Ser (L. & Ger)
	Name of medicine	About HOW OFTEN and HOW LONG did your child take this medicine?	1.				
.g. p	aracetamol, calpol, nurofen	e.g. four times a day for 2 weeks	2.				
_			3.				
_			4.				
_			5.				
_			_				
_			Par	t 6. Childe	are and other to its		
2	In the FIRST TWO WEEKS were BOUGHT WITHOUT	S after the accident, has your child taken any medicines that A PRESCRIPTION because of their accident? (Please < one box)	6.1	When you	took , our c ild who hi	ad the accident	to see a health professional, did you need
	Yes - please fill in the	table below		(PV /se - V	som one to look aft	er your other c	hildren and/or other people you care for?
	☐ No - please go to Secti	on 5.3		L Yes	□ No	☐ Not a	pplicable
	Please list all the medicines	bought without a prescription because of your child's accident?		If YES,			
	Name of medication	About HOW OFTEN and HOW LONG did your child take this medicine?		a) Who lool	ed after your children o	r the other people	e you care for? (please < all that apply)
.g. p	aracetamol, calpol, nurofen	e.g. four times a day for 2 weeks		П	Relative		
_							
_			CXV		Friend		
_			10		Professional carer (e.g. o	childminder)	
-			2	b) In total,		fter your children	n and/or the other people you care for?

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5

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6

☐ Yes ☐ No						☐ 30-39yrs	☐ 30-39yrs
If YES.						☐ 40-49yrs	☐ 40-49yrs
How many days care did your o	hild have? D	ays				☐ 50-59yrs	☐ 50-59yrs
How many hours care per day?	н	ours				☐ 60+yrs	□ 60+yrs
Part 7. Work and your child The next questions ask about time who have cared for your child in th care they have provided because o include your first visit to the A&E I Please think about the 2 people wt 1 and carer 2. One of these people	off work or usual activities of e FIRST TWO WEEKS after th f the accident, not care they w epartment, Minor Injuries Un to do most of the caring for yo	sir accident. Please only includ rould usually provide. [Please it or Walk-In Centre.] ur child. Call these people care	•	What best describes th usual activities? Please only		☐ Works full-time ☐ Works part-time ☐ Unemployed ☐ Retired	□ Works full- me □ V urks p. rt. me □ Unempl yed □ Letired
1 and carer 2. One of these people	may be you. Please fill in the	box below:				☐ Studen*	☐ Student
The 2 people who care most for your child	Carer 1	Carer 2				h susewifi, Sussand	☐ Housewife/husband
What is the relationship of this person to your child?	☐ Parent	☐ Parent				Oths: (please describe)	☐ Other (please describe)
person to your cine:	Relative (not parent)	☐ Relative (not parent)					
	☐ Friend	☐ Friend					
	Other (please describe)	Other (please describe)		Part 8. Tra el			
				5. 1. the VRST	TWO WEEKS of	ter the accident, did you spen	d any money on travelling to
Total number of days taken off work or usual activities, in the FIRST TWO WEEKS after the accident, by this			. 11	th. A&E department? [Ple	rtment, Minor : ase include your	Injuries Unit or Walk-In Centr first visit] (Please - one box)	e because of your child's
person to care for your child. Only include care provided because of the	Days	Days	M_{ℓ}	☐ Yes	□ No		
accident, e.g. if you took 3 days off work in the first week after the accident, and grandmother took 1 day off work in the			0 4.	If YES, please g	give details below	w.	
first week and 1 day off work in the second week to look after your child, you would write "3" in the carer 1 box and "2" in the carer 2 box.			SEV	USED PRIVATE	CAR		
Did this person lose any money from	☐ Yes	☐ Yes	113,	Yes N	Number of miles	for round trip miles	Cost of Parking
work because they were caring for your child?	□ No	□ No		USED PUBLIC T	TRANSPORT/TAX	I	
Sex of this person	☐ Male	□ Malr		☐ Yes R	Return fare (£)		
	☐ Female	☐ F∖ male		O 16 1	vecurii iare (E.)		
			•				

Less than 21yrs

21-29yrs

Age of this person

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Less than 21yrs

21-29yrs

6.2 In the FIRST TWO WEEKS after the accident, has your child who had the accident needed extra care that you paid for because of their accident? (Please < one box)</p>

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8.2	the hospita	ST TWO WEEKS after the accident, did you spend any money on travelling to all (other than to the A&E department, Minor Injuries Unit or Walk-In Centre) your child's accident? (Please Fone box)	Pa	rt 9. Other accidents				
	Yes	□ No		Most children have accidents at some time. How well they get better may be affected by having other accidents afterwards. This is why we are asking you about any other				
	If YES, pleas	se give details below.	9.1	accidents your child has had recently. Has your child visited the A&E department, Minor Injuries Unit or Walk-In Centre because				
	USED PRIVA	TE CAR		of an accident since//				
	☐ Yes	Number of miles for round brip miles Cost of Parking		☐ Yes ☐ No				
	USED PUBLI	C_TRANSPORT/TAXI		If YES, please tick why they went to A&E, Minor Injuries Unit or Walk-In Centre (Rease / all that apply)				
	☐ Yes	Return fare (£)		A slip, trip, fall or tumble on stairs or steps				
8.3	In the FIRST TWO WEEKS after the accident, did you spend any money on travelling to the GP's surgery because of your child's accident? (Please < one box)			A slip, trip, fall or tumble on the same level				
				A slip, trip, fall or tumble from furniture				
	Yes	□ No		Swallowing medicine or pills				
	If YES, pleas USED PRIVA	pe give details below.		Swallowing cleaning products or garden chr.nical.				
	☐ Yes	Number of miles for round trip miles Cost of Parking		A scald from hot water, other hot lis, (id + ' st. \re*				
	USED PUBLI	C TRANSPORT/TAXI		Other accident (Please Yesch, e).				
	Yes	Return fare (£)		What sort of accio, int. was .t? (Flease < all that apply)				
8.4		ST TWO WEEKS after the accident, did you spend any money travelling else because of your child's accident? (Flease \neq one δ ox.)		That for a reclousiness				
	Yes	□ No	11	ang on the head				
	If YES, pleas	se tell us where you travelled to and give details below.	A					
	Travelled to			☐Burn or scald				
	USED PRIVA			Swallowed household cleaner/other poison/pills				
	Yes	Number of miles for round trip miles Cost of Parking C. TRANSPORT/TAXI		Cut needing stitches				
	Yes	Return fare (E)		□Cut or graze				
		Made I I I I I I I I I I I I I I I I I I I		Other accident				
Study	C Resource Use	e Week 182 questionnaire v3 10 02 11	Study	C Resource Use Week 182 questionnaire v3 10 02 11 10				

Part 10. General Health

How is your child's health TODAY? Please put an "X" on the line below to indicate how good or how bad your child's health is:

Worst possible health

Perfect health



Part 11. Quality of Life

PedsQL™ Pediatric Quality of Life Inventory, Yersion 4.0

Parent Report for Toddlers (ages 2-4)

Part 12. Any Other Comments

			_
121	Please tell us the date you filled in this questionnaire:	 f	/

12.2 Are there any other costs that you have had to pay because of your child's accident and you have not been asked about them in this questionnaire? If YES, please tell us about them below:

12.3 Is there anything else you would like to tell us about your child's accident? If YES, please tell us below:

Thank you for taking the time to fill in this questionnaire. Please send it back in the FREEPOST envelope.



						1 1	$\overline{}$
_	-	_	_	_	_		

Keeping Children Safe: Measuring the cost of children's accidents



These questions ask about how much your child's accident cost you, your family and the NHS in the THIRD and FOURTH WEEKS after the accident and whether your child is getting better.

Part 1. Visits to your GP for your child's accident

1.1	In the THIRD and FOURTH WEEKS after the accident, how many times has your child
	visited any of these health professionals at your <u>GP's surgery</u> because of their accident? (please put 'O' if none)
	(pease for v v more)

	Number of visits
GP	
Practice nurse	
Other (please say who)	

Part 2. Visits to other health professionals for your child's accident

2.1 In the THIRD and FOURTH WEEKS after the accident, how many times has your child visited, or been visited at home by, one of these health professionals because of their accident? (please put '0' if none)

	Number of visits	Treatment site (e.g. home, clinic, name of hospital	Did you pay fo this visit?		
			Yes	No	
Doctor / Consultant				6	
Health visitor					
Physiotherapist			1)-	
Nurse (Don't include GP visits here)		101			
Other (please say who)(Don't include visits to Practice Nurse here)		7			

Study C Resource use Weeks 3 &4 questionnair* , 10 02 11

Part 3. Stays in hospital AND visits to the Day Case Unit for your child's accident

	1.1 In the THIRD and FOURTH WEEKS after the accident, has your child had to stay in hospital overnight or visit a day case unit because of their accident? (please < one box) Yes - please fill in the table below							
	No - please g							
	Admission Date	Discharge Date	Name of the hospital	Name of consultant (if known)	Name of ward (if known)			
Stay 1								
Stay 2								
Stay 3				10				
Stay 4				5				
Stay 5								
4.1 In PR	Part 4. Medicine and modifical applies for your child's accident 4.1 In the TP' AD and OURTH WEEKS after the accident, has your child taken any PRESCAID Direction sees because of their accident? (please of one box) Tyes - please fill in the table below No - please go to Section 4.2 Please list all medicines prescribed by a doctor or nurse because of your child's accident.							
	me of medicin- aracetamol, Cal		About HOW OFTEN and HOW LONG did your child take this medicine? e.g. four times a day for 2 weeks					
e.g. r	Nurofen	poi,	e.g. ro	or cines a day for 2 we	texs			
2.								
3.								
4.								
5.								

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1.2	In the THIRD and FOURTH that were BOUGHT WIT box)	H WEEKS after the ac THOUT A PRESCRIPT	ccident, has your child taken any medicines 10N because of their accident? (pirase \checkmark one	P	art	5. Childcare ar	nd other costs	ı		
	Yes - please fill in the t	able below		5.:	1	In the THIRD and	d FOURTH WEEKS	after the acci	ident, when yo	u took your child who ha
	☐ No - please go to Section	on 4.3				other children a provided because	nd/or other peop	le you care f	or? Please on	someone to look after you ly include care they hav ally provide. (please - on
	Please list all the medicines	bought without a presi	cription because of your child's accident.			box)	_	_		
	Name of medication	About HOW OFTE	N and HOW LONG did your child take this medicine?]		Yes	□ No	☐ Not ap	plicable	
.g. j	Paracetamol, Calpol, Nurofen	e.g	. four times a day for 2 weeks	1		If YES.				
١.						a) Who looked after	er your children or ti	he other people	you care fol ? (,	(ease - all chat apply)
-						☐ Relative			~ G	
]		Friend		_ //		
i.						☐ Profess	sional carer (e ,c c,	ldh. nac.		
.3			ocident, have you GOT ANY AIDS OR MADE or garden because of their accident? (please			b) In total, how lo	ing and to wook the	er your children	and/or the othe	er people you care for?
	Yes - please fill in the t	able below		5.3			d FOURTH WEEKS : e that you paid for			child who had the acciden (please < one box)
	☐ No - please go to Section	on 5		. \([] Yes	□ No			
						If YES,				
Гурс	e of Aid/Changes made (e.g. chair)	Wheel Cost of item (if known)								
		<u> </u>				How many days ca	re did your child hav	/e?	Days	
_						How many hours co	are per day?		Hours	
_										
				た レ						
		1								

Part 6. Work and your child's accident

The next questions ask about time off work or usual activities of the people (including yourself) who have cared for your child. Please only include care they have provided because of the accident, not care they would normally provide.

During the THIRD and FOURTH WEEKS after the accident, please think about the 2 people who do most of the caring for your child. Call these people carer 1 and carer 2. One of these people may be you. Please fill in the box below:

The 2 people who care most for your child	Carer 1	Carer 2
What is the relationship of this person to your child?	☐ Parent	☐ Parent
to your clina:	☐ Relative (not parent)	☐ Relative (not parent)
	☐ Friend	☐ Friend
	Other (please describe)	☐ Other (please describe)
Total number of days taken off work or usual activities by this person to care for your child in the THIRD and FOURTH WEEKS after the accident. Only include care provided because of the accident. E.g. if you took 4 days off in week THIRE and grandmother took 3 days off in week FOUR you would write "4" in the carer 1 box and "3" in the carer 2 box.	Days	Days
Did this person lose any money from	☐ Yes	☐ Yes
work because they were caring for your child?	□ No	□ No
Sex of this person	☐ Male	☐ Male
	☐ Female	☐ Female
Age of this person	Less than 21yrs	Less than 21yrs
	22-29yrs	22-29yrs
	☐ 30-39yrs	□ 30-39yrs
	☐ 40-49yrs	☐ 40-49yrs
	☐ 50-59yrs	11-53yrs
	□ 60+yrs	☐ 0+ ₃ rs

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	t best describes this person's usual	☐ Works full-time	☐ Works full-time
activ	ities? Please < ONE BOX only	☐ Works part-time	☐ Works part-time
		☐ Unemployed	Unemployed
		Retired	Retired
		☐ Student	☐ Student
		☐ Housewife/husband	☐ Housewife/husband
		Cther (please describe)	Other (please describe)
Pa 7.1	rt 7. Travel In the THIRD and FOURTH	WEEKS after the accident d	id you spend any money on
	travelling to the A&E departm your child's accident? (please	nent or Million Injuries Unit of one bax)	r Walk-In Centre because of
	☐ Yes ☐ No	M_{II}	
	If YES, please give detain below.		
	USED PRIVATE CA 7		
	☐ \s Number of miles for	r round trip miles Co	art of Darkins
		riodila dip fillies Co	st or Parking
	V. *D P BLIC TRANSPORT/TAXI		
	Yes Return fare (£)		
7.2	In the THIRD and FOURTH travelling to the hospital (oth Walk-In Centre) because of yo	her than to the A&E departm	ent or Minor Injuries Unit or
	☐ Yes ☐ No		
	If YES, please give details below.		
	USED PRIVATE CAR		
	Yes Number of miles for	r round trip miles Co	st of Parking
	USED PUBLIC TRANSPORT/TAXI		
	Yes Return fare (£)		
	Study C Resource use Weeks 3 84 que	stionnaire v3 10 02 11	6

			_	
7.3	In the THII travelling to	RD and FOURTH WEEKS after the accident, did you spend any money on the GP's surgery because of your child's accident? (please < one box)	Pa	rt 8. Other accidents
	☐ Yes	□ No		Most children have accidents at some time. How well they get better may be affected having other accidents afterwards. This is why we are asking you about any other
	If YES, please	e give details below.		accidents your child has had recently.
	USED PRIVA	TE CAR	8.1	Has your child visited the A&E department or Minor Injuries Unit or Walk-In Centre because of an accident in the THIRD and FOURTH WEEKS after the accident?
	☐ Yes	Number of miles for round trip miles Cost of Parking		Yes No
	USED PUBLIC	.TRANSPORT/TAXI		If YES, please tick why they went to A&E or Minor Inyas L Nt. YWa!In Centre (Please < all that apply)
	Yes	Return fare (E)		A slip, trip, fall or tumble on stairs or st. os
				A slip, trip, fall or tumble on harsaine were
7.4	In the THIR anywhere e	D and FOURTH WEEKS after the accident, did you spend any money travelling lse because of your child's accident? (please < one box)		A slip, trip, fall or turn. To in im turniture
	☐ Yes	□ No		☐ Swallow, or edk >> 2 pills
	If YES, please	e tell us where you travelled to and give details below.		Scallowing cleaning products or garden chemicals
	Travelled to			A scald from hot water, other hot liquid or steam
	USED PRIVA	TE CAR	. ())	
	☐ Yes	Number of miles for round trip miles Cost of Parking		Other accident (Please describe)
				What sort of accident was it? (Please ✓ all that apply)
	USED POBLIC	TRANSPORT/TAXI	$\langle V I \rangle$	Loss of consciousness
	Yes Yes	Return fare (£)	1,	☐ Bang on the head
				Broken bone
		, 151		☐ Burn or scald
		BE USL		☐ Swallowed household cleaner/other poison/pills
		B.C.		☐ Cut needing stitches
				☐ Cut or graze
				Other accident
		~101		
	Study C Resour	se use Wei, 's 3 &. questionnaire v3 10 02 11		Study C Resource use Weeks 3 84 questionnaire v3 10 02 11

Part 9. General Health

How is your child's health TODAY? Please put an "X" on the line below to indicate how good or how bad your child's health is:

ersion 4.0

BEUSED WITHOUT PERMISSION Worst possible health

Part 10. Quality of Life

PedsQL™ Pediatric Quality of Life Inventory, Version 4.0

Parent Report for Toddlers (ages 2-4)

12.3 Is there anything else you would like to tell us about your child's accident? If YES, please tell us below:

Thank you for taking the time to fill in this question naire. Please send it back in the FREEPOS, envelope.

$\overline{}$		

Keeping Children Safe: Measuring the cost of children's accidents



These questions ask about how much your child's accident cost you, your family and the NHS in the 3 MONTHS after the accident and whether your child is getting better.

Part 1. Visits to your GP for your child's accident

1.1		fent, how many times has your child visited any of these surgery because of their accident? (please put '0' if <u>none</u>)
		Number of visits
	GP	
	Practice nurse	
	Other (please say who)	

Part 2. Visits to other health professionals for your child's accident

2.1 In the 3 MONTHS after the accident, how many times has your child visited, or been visited at home by, one of these health professionals because of their accident? (please put 'U' if none)

	Number of visits	Treatment site (e.g. home, clinic, name of hospital	Did you pa for this (sit?
Doctor / Consultant			
Health visitor		-67-	
Physiotherapist			
Nurse (Don't include GP visits here)		1	
Other (please say who)(Don't include visits to Practice Nurse here)			

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Part 3. Stays in hospital AND visits to the Day Case Unit for your child's

,	visit a day case u				
l	Yes - please f	ill in the table be	Now	- 6/	
[☐ No - please g	o to Section 4		T(O)	•
	Admission Date	Discharge Date	Name of his hospi el	" of consultant (ir known)	Name of ward (if known)
ny 1					
ay 2					
ву 3					
ay 4					
ay 5					
	in the 3 MONTHS because of their	S after the acci accident? (plea	dent, has your chil se < one box)	r child's accident d taken any PRESCR	
(In the 3 MONTHS Decause of their Yes - please f	S after the accident? (plea accident? (plea fill in the table be to to Section 4.2	dent, has your chili se ∕one box) slow		IBED medicines
((In the 3 MONTHS Decause of their Yes - please f	6 after the accident? (plea accident? (plea fill in the table be to Section 4.2 icines <u>prescribed</u>	dent, has your chill se / one box) slow by a doctor or nurse	d taken any PRESCR	IBED medicines
(((in the 3 MONTHS secause of their Yes - please f No - please ge	S after the acci accident? (plea fill in the table be to Section 4.2 icines <u>prescribed</u>	dent, has your child se - one box) slow by a doctor or nurse out HOW OFTEN as	d taken any PRESCR	IBED medicines 's accident. our child take this
((i e.g.	In the 3 MONTHS secause of their Yes - please go No - please go Please list all medicinions arme of medicinions Paracetamol, Cal	S after the acci accident? (plea fill in the table be to Section 4.2 icines <u>prescribed</u>	dent, has your child se - one box) slow by a doctor or nurse out HOW OFTEN as	d taken any PRESCR because of your child ad HOW LONG did your medicine?	IBED medicines 's accident. our child take this
(((In the 3 MONTHS secause of their Yes - please go No - please go Please list all medicinions arme of medicinions Paracetamol, Cal	S after the acci accident? (plea fill in the table be to Section 4.2 icines <u>prescribed</u>	dent, has your child se - one box) slow by a doctor or nurse out HOW OFTEN as	d taken any PRESCR because of your child ad HOW LONG did your medicine?	IBED medicines 's accident. our child take this
(((In the 3 MONTHS secause of their Yes - please go No - please go Please list all medicinions arme of medicinions Paracetamol, Cal	S after the acci accident? (plea fill in the table be to Section 4.2 icines <u>prescribed</u>	dent, has your child se - one box) slow by a doctor or nurse out HOW OFTEN as	d taken any PRESCR because of your child ad HOW LONG did your medicine?	IBED medicines 's accident. our child take this
((F	In the 3 MONTHS secause of their Yes - please go No - please go Please list all medicinions arme of medicinions Paracetamol, Cal	S after the acci accident? (plea fill in the table be to Section 4.2 icines <u>prescribed</u>	dent, has your child se - one box) slow by a doctor or nurse out HOW OFTEN as	d taken any PRESCR because of your child ad HOW LONG did your medicine?	IBED medicines 's accident. our child take this

1.2			hild taken any medicines that were ause of their accident? (please < one box)	Pa	art 5	5. Childcare and other costs
	Yes - please fill in the tal	ble below		5.1		In the 3 MONTHS after the accident, when you took your child who had the accident
	☐ No - please go to Section	n 4.3				see a health professional, did you need to get someone to look after your other childr and/or other people you care for? Please only include care they have provided because the accident, not care they would normally provide. (please ~ one box)
	Please list all the medicines b	ought without a prescr	iption because of your child's accident.		[Yes No Not applicable
	Name of medication		and HOW LONG did your child take this medicine?		1	rys.
.g. f	Paracetamol, Calpol, Nurofen	e.g.	four times a day for 2 weeks			a) Who looked after your children or the other people you (see for: 'pb all that apply)
-						Relative
l.						Friend
١.						Li Friend
i.						Professional criter (e.g. cm. "minder)
1.3	In the 3 MONTHS after the help your child in the home	accident, have you o e or garden because	SOT ANY AIDS OR MADE ANY CHANGES to of their accident? (please < one box)		ь	b) In total, how lone div the, York after your children and/or the other people you care for? Do as
	Yes - please fill in the tal	ble below		5.2		In the 3 VONLHS after the accident, has your child who had the accident needed extra at that you paid for because of their accident? (please r one box)
	☐ No - please go to Section	n 5				Yes No
Гурс	of Aid/Changes made (e.g. chair)	Wheel Cost of item (if known)	Who bought this or gave you this? (e.g. (yourself, family, NHS, social services, other)			fyes,
				1111.		How many days care did your child have? Days How many hours care per day? Hours
-						
١.						

Study C Resource 3 MONTHS questionnaire v3 10 02 11 3 Study C Resource 3 MONTHS questionnaire v3 10 02 11

Part 6. Work and your child's accident

The next questions ask about time off work or usual activities of the people (including yourself) who have cared for your child. Please only include care they have provided because of the accident, not care they would normally provide.

During the 3 MONTHS after the accident, please think about the 2 people who do most of the caring for your child. Call these people carer 1 and carer 2. One of these people may be you. Please fill in the box below:

The 2 people who care most for your child	Carer 1	Carer 2
What is the relationship of this person to your child?	☐ Parent	☐ Parent
to your child?	Relative (not parent)	☐ Relative (not parent)
	☐ Friend	☐ Friend
	Other (please describe)	Other (please describe)
Total number of days taken off work or usual activities by this person to care for your child in the 3 MONTHS weeks after the accident. Only include care provided because of the accident. E.g. if you took 4 days off in week THRE and grandmother took 3 days off in week POUR you occuld sinke "4" in the carer 1 box and "3" in the carer 2 box.	Days	Days
Did this person lose any money from work because they were caring for your child?	Yes No	Yes
Sex of this person	☐ Male	☐ Male
	☐ Female	☐ Female
Age of this person	Less than 21yrs	Less than 21yrs
	☐ 22-29yrs	☐ 22-29yrs
	☐ 30-39yrs	20-39yrs
	☐ 40-49yrs	J-49yrs
	☐ 50-59yrs	□ 50-59yrs
	□ 60+yrs	□ 60+yrs
		I

Study C Resource 3 MONTHS question are 3 10 2 11

What best describes this person's usual activities? Please < ONE BOX only	☐ Works full-time	☐ Works full-time						
BLUTIONS' PANSE T ONE DUX UNITY	☐ Works part-time	☐ Works part-time						
	☐ Unemployed	☐ Unemployed						
	Retired	Retired						
	☐ Student	☐ Student						
	☐ Housewife/husband	☐ Housewife/husband						
	Other (please describe)	C c. '4 (please describe)						
	2 GN							
Part 7. Travel								
7.1 In the 3 MONTHS after the ac	c. > >t. id. you enend any mo	nev on travelling to the ARE						
department or Minor Inju (please < one box)	Un to Vala-In Centre becau	use of your child's accident?						
Yes L' No								
If YES. Gease giv. details below.								
USL 7 PRI. ATE CAR								
~/·) '								
res Number of miles for	round trip miles Cos	t of Parking						
USED PUBLIC TRANSPORT/TAXI								
Yes Return fare (£)								
7.2 In the 3 MONTHS after the	accident, did vou spend anv	money on travelling to the						
hospital (other than to the Al because of your child's acciden	&E department or Minor Inju							
☐ Yes ☐ No								
If YES, please give details below.								
USED PRIVATE CAR								
Yes Number of miles for	round trip miles Cos	t of Parking						
USED PUBLIC TRANSPORT/TAXI								
Yes Return fare (£)								

7.3	In the 3 MONT surgery becaus	HS after the accident, did you spend any money on travelling to the G e of your child's accident? (please < one box)	P's	Par	t 8. Other accidents
	☐ Yes	□ No			Most children have accidents at some time. How well they get better may be affected having other accidents afterwards. This is why we are asking you about any other accidents your child has had recently.
	If YES, please giv				Has your child visited the A&E department or Minor Injuries Unit or Walk-In Centre
	USED PRIVATE C	48			because of an accident in the 3 MONTHS after the accident?
	Yes Nu	mber of miles for round trip miles Cost of Parking			Yes No
	USED PUBLIC TR	ANSPORT/TAXI			If YES, please tick why they went to ASE or Minor Injuries Unit or Walk-In Certre (Please ~ all that apply)
	☐ Yes Re	turn fare (£)			A slip, trip, fall or tumble on stairs or steps
7.4	To the 2 MONT	HS after the accident, did you spend any money travelling anywhere e	also.		A slip, trip, fall or tumble on the same level
	because of you	ns areer the accident, did you spend any money travelling anywhere e child's accident? (please < one box)	ise		A slip, trip, fell or tumble from furniture
	Yes Yes	□ No			Swallowing medicine or pills
		us where you travelled to and give details below.			Swallowing cleaning proc. You You den chemicals
	Travelled to				A scald from ho way v, ciher hot liquid or steam
	USED PRIVATE C	96			Cthi accident (Please describe)
	Yes Nu	mber of miles for round trip miles Cost of Parking			What yort of accident was it? (Rease < all that apply)
	USED PUBLIC TR	ANSPORT/TAXI			Loss of consciousness
	☐ Yes Re	turn fare (£)			☐ Bang on the head
					☐ Broken bone
					☐ Burn or scald
			CU		☐ Swallowed household cleaner/other poison/pills
		OBEUS			☐ Cut needing stitches
					☐ Cut or graze
		B.C.			☐ Other accident
		<0°			
	Study C Resource 3	MONTHS questionnaire v3 1、02 11	7	5	Study C Resource 3 MONTHS questionnaire v3 10 02 11
		No			

Part 9. General Health

How is your child's health TODAY? Please put an "X" on the line below to indicate how good or how bad your child's health is:

ersion 4.0

BEUSED WITHOUT PERMISSION Worst possible health

Part 10. Quality of Life

PedsQL™ Pediatric Quality of Life Inventory, Version 4.0

Parent Report for Toddlers (ages 2-4)

12.3 Is there anything else you would like to tell us about your child's accident? If YES, please tell us below:

Thank you for taking the time to fill in this que do main. Please send it back in the FREEPOST envelope.

		-	$\overline{}$			$\overline{}$	 \neg
		- 1					
		- 1					
-	_			_	-	-	 _

Keeping Children Safe: Measuring the cost of children's accidents



These questions ask about how much your child's accident cost you, your family and the NHS in the 6 MONTHS after the accident and whether your child is getting better.

Part 1. Visits to your GP for your child's accident

1.1		ent, how many times has your child visited any of thes <u>surgery</u> because of their accident? (pirase put '0' if <u>none</u>
		Number of visits
	GP	
	Practice nurse	
	Other (please say who)	

Part 2. Visits to other health professionals for your child's accident

2.1 In the 6 MONTHS after the accident, how many times has your child visited, or been visited at home by, one of these health professionals because of their accident? (please put "0" // name).

	Number of visits	Treatment site (e.g. home, clinic, name of hospital	Did you this vis	pay for it?
			Yes	No
Doctor / Consultant				
Health visitor				
Physiotherapist				
Nurse (Don't include GP visits here)		0		
Other (please say who)(Don't include visits to Practice Nurse here)		V.		

Study C Resource 6 MONTH question .a. > v3 10 02 1.

Part 3. Stays in hospital AND visits to the Day Case Unit for your child's

vi		mit because of	their accident? (p	ld had to stay in hosp Nease < one box)	oital overnight or
	No - please g				
	Admission Date	Discharge Date	Name of the hospital	Name of consult nt	Name of ward (if known)
Stay 1					
Stay 2					
Stay 3					
Stay 4					
Stay 5					
	No - please go			e because of your child	's accident.
Na	me of medicin	e Ab	out HOW OFTEN a	ind HOW LONG did yo medicine?	ur child take this
e.g. F	Paracetamol, Cal Nurofen	pol,	e.g. fo	ur times a day for 2 we	eks
1.					
2.					
3.					
4.					
5.					

4.2	In the 6 MONTHS after th BOUGHT WITHOUT	he accident, ha T A PRESCRIPT	s your chil TION becau	ld taken any medicines use of their accident? (;	that were please < one box)		Part	t 5. Childcare a	and other costs		
	Yes - please fill in the	table below					5.1	To the 6 MONTE	IS after the acciden	t when you took your	child who had the accident
	☐ No - please go to Section	on 4.3					3.1	see a health pro and/or other pe	ofessional, did you n ople you care for? P	eed to get someone to I	look after your other childre hey have provided because
	Please list all the medicines	bought without	a prescript	tion because of your child	's accident.			Yes	□ No	☐ Not applicable	one busy
	Name of medication	About HOV	W OFTEN a	nd HOW LONG did your	child take this				LI NO	☐ Not applicable	
e.g.	Paracetamol, Calpol, Nurofen		e.g. for	medicine? ur times a day for 2 week	s			If YES,			
1.								a) Who looked at	ter your children or the	e other people you care for	? (Nease < all that apply)
2.								Relati	ve		
3.								☐ Friend		~1()	
4.										~610	
5.								☐ Profes	ssional carer (e.g. c. Vo	(Carried	
								b) In total, how I	ong did (v loc ca ter	our children and/or the o	other people you care for?
4.3	In the 6 MONTHS after th help your child in the hor	he accident, ha	ive you GO because of	T ANY AIDS OR MADE	ANY CHANGES to			Days	Or 4		
	,,,						5.3	To the 6 MO T	2 at as the assistant	has your shild who had	the accident needed extra
	Yes - please fill in the	table below					3.2	care lat ou v	id for because of the	eir accident? (please - on	e box)
	☐ No - please go to Secti	ion S						☐ Yes	□ No		
	_ 10								□ No		
Тур	of Aid/Changes made (e.g		of item	Who bought this or ga	ve you this? (e.g.		V	If YES,			
1.	chair)	(IT R	cnown)	(yourself, family, NHS, so	clai services, other)	., 10		How many days o	are did your child have	9? Days	s
2.			-					How many hours	care per day?	Hou	rs
3.			-								
4.			-								
5.			-								
					CKY						
					17						
)						
				OK.							
				YO Y							
			- ()								
				,							
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		ノ									
	12										

Part 6. Work and your child's accident

The next questions ask about time off work or usual activities of the people (including yourself) who have cared for your child. Please only include care they have provided because of the accident, not care they would normally provide.

During the 6 MONTHS after the accident, please think about the 2 people who do most of the caring for your child. Call these people carer 1 and carer 2. One of these people may be you. Please fill in the box below:

The 2 people who care most for your child	Carer 1	Carer 2	
What is the relationship of this person to your child?	Parent Relative (not parent) Friend Other (please describe)	Parent Relative (not parent) Friend Other (please describe)	P:
Total number of days taken off work or usual activities by this person to care for your dilid in the 6 MONTHS weeks after the accident. Only include care provision because of the accident. E.g. If you took 4 took 3 days off in week FOUR you would write "4" in the carer 1 box and "3" in the carer 2 box.	Days	Days	
Did this person lose any money from work because they were caring for your child?	Yes	Yes	ITHO
Sex of this person	☐ Male ☐ Female	Male	7.2
Age of this person	Less than 21yrs 22-29yrs 30-39yrs 40-49yrs 50-5 yrs	Less than 21y . 22- Tyrs 40-49yrs 50-59yrs 60+yrs	

Study C Resource 6 MONT / quest, nnain, v3 10 02 11

	best describes this person's usual ties? Please < ONE BOX only	☐ Works full-time	☐ Works full-time						
activii	DEST PRESE - ONE BUX ONLY	☐ Works part-time	☐ Works part-time						
		☐ Unemployed	☐ Unemployed						
		Retired	Retired						
		Student	☐ Student						
		☐ Housewife/husband	☐ Housewife/husband						
		Other (please / Sc. \e)	Other (please describe)						
		651							
Par	t 7. Travel	157							
7.1	In the 6 MONTHS for the videpartment or h nor Inj. ries (please or our)	ideat, did you spend any mo Unit or Walk-In Centre beca	ney on travelling to the A&E use of your child's accident?						
	□ Y s □ No								
	If YES, pl. yse give details below.								
	L. ED PRIVATE CAR								
	Yes Number of miles for round trip miles Cost of Parking								
	USED PUBLIC TRANSPORT/TAXI								
	Yes Return fare (£)								
7.2	In the 6 MONTHS after the	accident, did you spend any	money on travelling to the						
/	hospital (other than to the A because of your child's accide	&E department or Minor Inju	ries Unit or Walk-In Centre)						
	Yes No								
	If YES, please give details below.								
	USED PRIVATE CAR								
	Yes Number of miles fo	r round trip miles Co	st of Parking						
	USED PUBLIC TRANSPORT/TAXI								
	Yes Return fare (£)								

7.3	In the 6 MC surgery bec	ONTHS	after the accident, did f your child's accident?	you spend any (please < one box	money on travelling	to the GP's		Par	rt 8. Other accidents
	Yes		□ No						Most children have accidents at some time. How well they get better may be affected by having other accidents afterwards. This is why we are asking you about any other accidents your child has had recently.
	If YES, please USED PRIVAT							8.1	Has your child visited the A&E department or Minor Injuries Unit or Walk-In Centre because of an accident in the 6 MONTHS after the accident?
									Yes No
	Yes		er of miles for round trip	miles	Cost of Parking	***			If YES, please tick why they went to A&E or Minor Injuries Unit or Walk-In Centre
	USED PUBLIC	C TRAM:	SPORI//AXI						(Please < all that apply)
	Yes	Return	n fare (£)						A slip, trip, fall or tumble on stairs or steps
7.4	In the 6 MC	ONTHS	after the accident, did hild's accident? (please -	you spend any	money travelling ar	ywhere else			A slip, trip, fall or tumble on the same level
		your cr		one box)					A slip, trip, fall or tumble from furnif ire
	Yes		□ No						Swallowing medicine or pills
	If YES, please Travelled to		s where you travelled to an	d give details bel	ow.				Swallowing cle nin; pro 'uct, ir garden chemicals
	USED PRIVAT								As: 1 fr not water, other hot liquid or steam
	Yes	North	er of miles for round trip		Control Design				☐ Oth accident (Please describe)
	USED PUBLIC			miles	Cost or Parking	***			W at sort of accident was it? (Please < all that apply)
		2 77041.	2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2				. (()		Loss of consciousness
	Yes	Return	n fare (£)				11/10		☐ Bang on the head
							41///		Broken bone
							111.		Burn or scald
						$\langle \langle \langle \rangle \rangle$			Swallowed household cleaner/other poison/pills
					10				☐ Cut needing stitches
					/ \)				☐ Cut or graze
				0	EU				☐ Other accident
				01					
				\cup					
	Study C Resour	roe 6 MO	NTH question one v3 10 02	11		7		5	Study C Resource 6 MONTH questionnaire v3 10 02 11
		1	7O,						

.1			ted the A&E department or Minor Injuries Unit or Walk-In Co dent in the 6 MONTHS after the accident?	entre
		Yes	□ No	
		ES, please tick w ase ✓all that ap	hy they went to A&E or Minor Injuries Unit or Walk-In Centre	
		A slip, trip, fall	or tumble on stairs or steps	
		A slip, trip, fall	or tumble on the same level	
		A slip, trip, fall	or tumble from furnit tre	
		Swallowing med	licine or pills	
		Swallowing cle	nins pro 'ucı, ir garden chemicals	
		A == 1 fr. =. no	w ter, other hot liquid or steam	
		Oths: accident (Please describe)	
\	W	at sort of accid	ent was it? (Please < all that apply)	
		Loss of consciou	sness	
		Bang on the hea	d	
		Broken bone		
		Burn or scald		
		Swallowed hous	ehold cleaner/other poison/pills	
		Cut needing stit	ches	
		Cut or graze		
		Other accident		

Part 9. General Health

How is your child's health TODAY? Please put an "X" on the line below to indicate how good or how bad your child's health is:

Worst possible health Perfect health

Part 10. Quality of Life

NOT TO BE PedsQL[™] Pediatric Quality of Life Inventory, Version 4.0

Parent Report for Toddlers (ages 2-4)

Part 11. Your Child
11.1 Do you think your child is now completely better and their accident is not affecting them anymore? (Please < one box)
Yes No
Part 12. Any Other Comments
12.1 Please tell us the date you filled in this questionnaire:/
12.2 Are there any other costs that you have had to pay because of your child's accident and you have not been asked about them in this questionnaire? If YES, please tell us about them below:



12.3 Is there anything else you would like to tell us about your child's accident? If YES, please tell us below:

Thank you for taking the time to fill in this questionnaire. Pleas, send it book in the FREEPOST envelope.

\Box						
-	_	-	_	 _	_	

Keeping Children Safe: Measuring the cost of children's accidents



These questions ask about how much your child's accident cost you, your family and the NHS in the 12 MONTHS after the accident and whether your child is getting better.

Part 1. Visits to your GP for your child's accident

1.1	In the 12 MONTHS after the accident, how many times has your child visited any of the health professionals at your <u>GP's surgery</u> because of their accident? (pirase put '0' if no	
	Number of visits	
	60	

Practice nurse
Other (please say who)

Part 2. Visits to other health professionals for your child's accident

2.1 In the 12 MONTHS after the accident, how many times has your child visited, or been visited at home by, one of these health professionals because of their accident? (please put '0' // nace).

	Number of visits	Treatment site (e.g. home, clinic, name of hospital	Did you pay for this visit?		
			Yes	No	
Doctor / Consultant					
Health visitor			1		
Physiotherapist					
Nurse (Don't include GP visits here)		0			
Other (please say who)(Don't include visits to Practice Nurse here)					

Study C Resource 12 MONTHS questionnaire v7 10 92 11

Part 3. Stays in hospital AND visits to the Day Case Unit for your child's accident $% \left(1\right) =\left(1\right) \left(1$

	Yes - please f	ill in the table be to Section 4	dow		
	Admission Date	Discharge Date	Name of the hospital	Name of consultant (# known)	Name of ward (ii
Stay 1					11/2
Stay 2					
Stay 3					
Stay 4					
Stay 5					
				ur child's accident	
Pie	Ye please for No - please go	ill in the table be to Section 4.2 icines prescribed	se vione box) llow by a doctor or nur	hild taken any PRESC	's accident.
Ple	Ye please of	ill in the table be to Section 4.2 citines prescribed	by a doctor or nur		's accident. our child take this

4.2	In the 12 MONTHS after t BOUGHT WITHOUT	the accident, has T A PRESCRIPTIO	your ch ON becau	ild taken any medicines that were use of their accident? (please < one box)		Part	t 5. Childcare and	other costs		
	Yes - please fill in the t	table below				5.1	In the 12 MONTHS	after the accident	, when you took your o	hild who had the accident
	☐ No - please go to Section	on 4.3					and/or other people	e you care for? Ple		ook after your other childre hey have provided because
	Please list all the medicines	bought without a	prescripti	ion because of your child's accident.			_	No No		one box)
	Name of medication	About HOW	OFTEN as	nd HOW LONG did your child take this				□ No	☐ Not applicable	
e.g. F	Paracetamol, Calpol, Nurofen		e.g. fou	medicine? or times a day for 2 weeks			If YES,			
1.							a) Who looked after t	your children or the	other people you care for	(please all that apply)
2.							Relative			
3. 4.							Friend		-611) `
5.							☐ Profession	nal carer (e.g. childr	Title YJ	
4.3				OT ANY AIDS OR MADE ANY CHANGES to their accident? (picase < one box)				did they loo . 9er	ou children and/or the o	ther people you care for?
	Yes - please fill in the t	table below				5.2	In the 12 MO' 'S care that you paid f	or the accident, to be ause of their	has your child who had r accident? (please / one	d the accident needed extra e box)
	☐ No - please go to Secti	ion 5					LT Yes	□ No		
Турс	of Aid/Changes made (e.g.	. Wheel Cost of	f item	Who bought this or gave you this? (e.g.			If Y' 5.			
1.	chair)	(if kno	own) ((yourself, family, NHS, social services, other)	14.		How many days care	did your child have?	Days	
2.			\rightarrow				How many hours care	e per day?	Hour	rs .
3.			_							
4.			_							
5.			-							
J.										
				ar USF						
				Br						
			1	O '						
	Study C Resource 12 MONTHS q	questionnal.e \ \ 10.0	02 11	3			Study C Resource 12 MOR	NTHS questionnaire v3	10 02 11	
	1	70,								

Part 6. Work and your child's accident

The next questions ask about time off work or usual activities of the people (including yourself) who have cared for your child. Please only include care they have provided because of the accident, not care they would normally provide.

During the 12 MONTHS after the accident, please think about the 2 people who do most of the caring for your child. Call these people carer 1 and carer 2. One of these people may be you. Please fill in the box below:

The 2 people who care most for your child	Carer 1	Carer 2	
What is the relationship of this person to your child?	☐ Parent	☐ Parent	
	Relative (not parent)	☐ Relative (not parent)	L
	☐ Friend	☐ Friend	
	☐ Other (please describe)	Other (please describe)	-
Total number of days taken off work or usual activities by this person to care for your child in the 12 MONTHS weeks after the accident. Only include care provided because of the accident. E.g. if you took 4 days off in week THREE and grandmother took 3 days off in week FOUR you would write "4" in the carer 1 box and "3" in the carer 2 box.	Days	Days	7.
Did this person lose any money from	☐ Yes	☐ Yes	110
work because they were caring for your child?	□ No	□ No	
Sex of this person	☐ Male	☐ Male	7.
	☐ Female	☐ Female	
Age of this person	Less than 21yrs	Less th7., 21y.	Y
	22-29yrs	22-2. VIS	
	☐ 30-39yrs	3 -39 /8	
	☐ 40-49yrs	40-49yrs	
	□ 50-59 rs	☐ 50-59yrs	
	□ 1.0+AV	☐ 60+yrs	

Study C Resource 12 MONT (5 que, 10nn), re v3 10 02 11

What best describes this person's usua activities? Please < ONE BOX only	☐ Works full-time	☐ Works full-time					
activities? Please & One BUX only	☐ Works part-time	☐ Works part-time					
	☐ Unemployed	□ Unemployed					
	Retired	Retired					
	Student	☐ Student					
	☐ Housewife/husband	☐ Housewife/husband					
	Other (please de	Other (please describe)					
Part 7. Travel							
7.1 In the 12 MONTHS #fter to department or M(or)nju is (please / one / a)	ac tid. at, did you spend any me s Init or Walk-In Centre beca	oney on travelling to the A&E use of your child's accident?					
Yc. No 'f YES, pk vse give details below.							
U. SD PRIVATE CAR							
Yes Number of miles	Yes Number of miles for round brip miles Cost of Parking						
USED PUBLIC TRANSPORT/TAX							
Yes Return fare (£) .							
	e accident, did you spend any						
hospital (other than to the because of your child's accid	A&E department or Minor Inju ent? (please < one box)	ries Unit or Walk-In Centre)					
П							
☐ Yes ☐ No							
	If YES, please give details below.						
USED PRIVATE CAR							
Yes Number of miles	for round trip miles Co	st of Parking					
USED PUBLIC TRANSPORT/TAX	USED PUBLIC TRANSPORT/TAXI						
Yes Return fare (£) .							

7.3	the 12 MONTHS after the accident, did you spend any money on travelling to the GP's pery because of your child's accident? (please -/ one box)		art 8. Other accidents		
	Yes No		Most children have accidents at some time. How well they get better may be affected by having other accidents afterwards. This is why we are asking you about any other accidents your child has had recently.		
	If YES, please give details below.	8.1	Has your child visited the A&E department or Minor Injuries Unit or Walk-In Centre		
	<u>USED PRIVATE CAR</u>	8.1	because of an accident in the 12 MONTHS after the accident?		
	Yes Number of miles for round trip miles Cost of Parking		Yes No		
	USED PUBLIC TRANSPORT/TAXI		If YES, please tick why they went to ASE or Minor Injuries Unit or Walk-*- Co tro (Please < all that apply)		
	Yes Return fare (£)		A slip, trip, fall or tumble on stairs or steps		
7.4	In the 12 MONTHS after the accident, did you spend any money travelling anywhere else because of your child's accident? (please < one box)		A slip, trip, fall or tumble on the same level		
			A slip, trip, fell or tumble from fur ture		
	Yes No		Swallowing medicine c. pilk.		
	If YES, please tell us where you travelled to and give details below.		Swallowing ci. anin) pr. dur's or garden chemicals		
	Travelled to		A scala from hot vater, other hot liquid or steam		
	VSED PRIVATE CAR		C Othi r accident (Please describe)		
	Yes Number of miles for round trip miles Cost of Parking		/hat sort of accident was it? (Please < all that apply)		
	USED PUBLIC TRANSPORT/TAXI	1	Loss of consciousness		
	☐ Yes Return fare (£)	☐ Bang on the head			
			Broken bone		
	BEUSEN		☐ Burn or scald		
			Swallowed household cleaner/other poison/pills		
			Cut needing stitches		
	BE.		☐ Cut or graze		
			☐ Other accident		
	Study C Resource 12 MONTHS ques for like v3 0 02 11 7		Study C Resource 12 MONTHS questionnaire v3 10 02 11		

Part 9. General Health

How is your child's health TODAY? Please put an "X" on the line below to indicate how good or how bad your child's health is:

		OUT PERMISSION
Worst possible health	Perfect health	610,
		2/1/2
		SERIV
Ovelity of Life	(90.
. Quality of Life		
™ Pediatric Quality of Life Inventory	, Version 4.0	
Report for Toddlers (ages 2-4)	, CEV	
	v, Version 4.0	
	Br	
770		
~101		

Part 10. Quality of Life

Part 11. Your Child				
11.1 Do you think your child is now completely better and their accident is not affecting them anymore? (Rease < one box) Yes No				
Part 12. Any Other Comments				
12.1 Please tell us the date you filled in this questionnaire:/				
12.2 Are there any other costs that you have had to pay because of your child's accident and you have not been asked about them in this questionnaire? If YES, please tell us about them below:				

12.3 Is there anything else you would like to tell us about your child's accident? If YES, please tell us below:

Thank you for taking the time to fill in this quast on, vir.. Please send it back in the FREEP's Tenve or 4.

