Participant Information Sheet
Version 01

You have been given this booklet to complete for this study. This booklet contains some questions about your 'quality of life' and/or the side effects you may be experiencing. Your answers will help us to better understand how taking part in this study is affecting the way you feel.

1. This booklet contains a set of questions you are asked to complete.

2. Please follow the directions in each questionnaire.

3. You may choose not to answer any questions that make you feel uncomfortable.

4. You may receive the booklet in person, by mail, or electronically by e-mail for you to print (PDF).

5. Please complete the booklet during your scheduled clinic visit if possible, and return it to your nurse, doctor, or research coordinator. You may also complete the booklet at home and return it to your nurse, doctor, or research coordinator at your next clinic visit or return it by mail. **Please initial and date the booklet below when you complete it.**

6. It is possible that clinic staff may contact you to provide your responses to the questions by telephone or video.

Thank you for taking the time to help us.

To be completed by the participant:

Participant Initials: _____

Date Completed:_____

PRO-CTCAE* -NCI-PRO-CTCAE™ ITEMS

Item Library version 1.0

As individuals go through treatment for their cancer they sometimes experience different symptoms and side effects. For each question, please check or mark an ⊠ in the one box that best describes your experiences over the past 7 days.

1a. In the last 7 days, what was the SEVERITY of your DECREASED APPETITE at its WORST?				
O None	O Mild	O Moderate	O Severe	O Very severe
1b. In the last 7 days, how much did DECREASED APPETITE INTERFERE with your usual or daily activities?				
O Not at all	OA little bit	O Somewhat	O Quite a bit	O Very much

2a. In the last 7 days, how OFTEN did you have NAUSEA?				
O Never	O Rarely	O Occasionally	O Frequently	O Almost constantly
2b. In the last 7 days, what was the SEVERITY of your NAUSEA at its WORST?				
O None	O Mild	O Moderate	O Severe	O Very severe

3a. In the last 7 days, how OFTEN did you have VOMITING?				
O Never	O Rarely	O Occasionally	O Frequently	O Almost constantly
3b. In the last 7 days, what was the SEVERITY of your VOMITING at its WORST?				
O None	O Mild	O Moderate	O Severe	O Very severe

4a. In the last 7 days, how OFTEN did you have LOOSE OR WATERY STOOLS (DIARRHEA/DIARRHOEA)?				
O Never	O Rarely	O Occasionally	O Frequently	O Almost constantly

5a. In the last 7 days, how OFTEN did you have PAIN IN THE ABDOMEN (BELLY AREA)?				
O Never	O Rarely	O Occasionally	O Frequently	O Almost constantly
5b. In the last 7 days, what was the SEVERITY of your PAIN IN THE ABDOMEN (BELLY AREA) at its WORST?				
O None	O Mild	O Moderate	O Severe	O Very severe
5c. In the last 7 days, how much did PAIN IN THE ABDOMEN (BELLY AREA) INTERFERE with your usual or daily activities?				
O Not at all	O A little bit	O Somewhat	O Quite a bit	O Very much

6a. In the last 7 days, what was the SEVERITY of your SHORTNESS OF BREATH at its WORST?				
O None	O Mild	O Moderate	O Severe	O Very severe
6b. In the last 7 days, how much did your SHORTNESS OF BREATH INTERFERE with your usual or daily activities?				
O Not at all	O A little bit	O Somewhat	O Quite a bit	O Very much

7a. In the last 7 days, did you have any RASH?	
O Yes	O No

8a. In the last 7 days, what was the SEVERITY of your SKIN BURNS FROM RADIATION at their WORST?					
O None	O Mild	O Moderate	O Severe	O Very severe	O Not applicable

9a. In the last 7 days, what was the SEVERITY of your NUMBNESS OR TINGLING IN YOUR HANDS OR FEET at its WORST?				
O None	O Mild	O Moderate	O Severe	O Very severe
9b. In the last 7 days, how much did NUMBNESS OR TINGLING IN YOUR HANDS OR FEET INTERFERE with your usual or daily activities?				
O Not at all	O A little bit	O Somewhat	O Quite a bit	O Very much

10a. In the last 7 days, how OFTEN did you have ACHING MUSCLES?				
O Never	O Rarely	O Occasionally	O Frequently	O Almost constantly
10b. In the last 7 days, what was the SEVERITY of your ACHING MUSCLES at their WORST?				
O None	O Mild	O Moderate	O Severe	O Very severe
10c. In the last 7 days, how much did ACHING MUSCLES INTERFERE with your usual or daily activities?				
O Not at all	O A little bit	O Somewhat	O Quite a bit	O Very much

11a. In the last 7 days, how OFTEN did you have ACHING JOINTS (SUCH AS ELBOWS, KNEES, SHOULDERS)?				
O Never	O Rarely	O Occasionally	O Frequently	O Almost constantly
11b. In the last 7 days, what was the SEVERITY of your ACHING JOINTS (SUCH AS ELBOWS, KNEES, SHOULDERS) at their WORST?				
O None	O Mild	O Moderate	O Severe	O Very severe
11c. In the last 7 days, how much did ACHING JOINTS (SUCH AS ELBOWS, KNEES, SHOULDERS) INTERFERE with your usual or daily activities?				
O Not at all	O A little bit	O Somewhat	O Quite a bit	O Very much

12a. In the last 7 days, what was the SEVERITY of your FATIGUE, TIREDNESS, OR LACK OF ENERGY at its WORST?				
O None	O Mild	O Moderate	O Severe	O Very severe
12b. In the last 7 days, how much did FATIGUE, TIREDNESS, OR LACK OF ENERGY INTERFERE with your usual or daily activities?				
O Not at all	O A little bit	O Somewhat	O Quite a bit	O Very much

13a. In the last 7 days, what was the SEVERITY of your BREAST AREA ENLARGEMENT OR TENDERNESS at its WORST?				
O None	O Mild	O Moderate	O Severe	O Very severe

OTHER SYMPTOMS					
Do you have any other symptoms that you wish to report?					
O Yes		O No			
Please list any other symptoms:					
1.	In the last 7 days, what was the SEVERITY of this symptom at its WORST?				
	O None	O Mild	O Moderate	O Severe	O Very Severe
2.	In the last 7 days, what was the SEVERITY of this symptom at its WORST?				
	O None	O Mild	O Moderate	O Severe	O Very Severe
3.	In the last 7 days, what was the SEVERITY of this symptom at its WORST?				
	O None	O Mild	O Moderate	O Severe	O Very Severe
4.	In the last 7 days, what was the SEVERITY of this symptom at its WORST?				
	O None	O Mild	O Moderate	O Severe	O Very Severe
5.	In the last 7 days, what was the SEVERITY of this symptom at its WORST?				
	O None	O Mild	O Moderate	O Severe	O Very Severe

Below is a list of statements that other people with your illness have said are important**.**
Please circle or mark one number per line to indicate your response as it applies to the <u>past 7 days</u>.

	PHYSICAL WELL-BEING	**Not at all**	**A little bit**	**Some-what**	**Quite a bit**	**Very much**
GP1	I have a lack of energy	0	1	2	3	4
GP2	I have nausea	0	1	2	3	4
GP3	Because of my physical condition, I have trouble meeting the needs of my family	0	1	2	3	4
GP4	I have pain	0	1	2	3	4
GP5	I am bothered by side effects of treatment	0	1	2	3	4
GP6	I feel ill	0	1	2	3	4
GP7	I am forced to spend time in bed	0	1	2	3	4

English (Universal) 16 November 2007

SOCIAL/FAMILY WELL-BEING

		Not at all	A little bit	Some-what	Quite a bit	Very much
GS1	I feel close to my friends	0	1	2	3	4
GS2	I get emotional support from my family	0	1	2	3	4
GS3	I get support from my friends	0	1	2	3	4
GS4	My family has accepted my illness	0	1	2	3	4
GS5	I am satisfied with family communication about my illness	0	1	2	3	4
GS6	I feel close to my partner (or the person who is my main support)	0	1	2	3	4
Q1	*Regardless of your current level of sexual activity, please answer the following question. If you prefer not to answer it, please mark this box* ☐ *and go to the next section.*					
GS7	I am satisfied with my sex life	0	1	2	3	4

Please circle or mark one number per line to indicate your response as it applies to the <u>past 7 days</u>.

	EMOTIONAL WELL-BEING	**Not at all**	**A little bit**	**Some-what**	**Quite a bit**	**Very much**
GE1	I feel sad	0	1	2	3	4
GE2	I am satisfied with how I am coping with my illness	0	1	2	3	4
GE3	I am losing hope in the fight against my illness	0	1	2	3	4
GE4	I feel nervous	0	1	2	3	4
GE5	I worry about dying	0	1	2	3	4
GE6	I worry that my condition will get worse	0	1	2	3	4

English (Universal) 16 November 2007

FUNCTIONAL WELL-BEING

		Not at all	A little bit	Some-what	Quite a bit	Very much
GF1	I am able to work (include work at home)	0	1	2	3	4
GF2	My work (include work at home) is fulfilling	0	1	2	3	4
GF3	I am able to enjoy life	0	1	2	3	4
GF4	I have accepted my illness	0	1	2	3	4
GF5	I am sleeping well	0	1	2	3	4
GF6	I am enjoying the things I usually do for fun	0	1	2	3	4
GF7	I am content with the quality of my life right now	0	1	2	3	4

English (Universal) 16 November 2007

Please circle or mark one number per line to indicate your response as it applies to the <u>past 7 days</u>.

	ADDITIONAL CONCERNS	**Not at all**	**A little bit**	**Some-what**	**Quite a bit**	**Very much**
B1	I have been short of breath	0	1	2	3	4
B2	I am self-conscious about the way I dress	0	1	2	3	4
B3	One or both of my arms are swollen or tender	0	1	2	3	4
B4	I feel sexually attractive	0	1	2	3	4
B5	I am bothered by hair loss	0	1	2	3	4
B6	I worry that other members of my family might someday get the same illness I have	0	1	2	3	4
B7	I worry about the effect of stress on my illness	0	1	2	3	4
B8	I am bothered by a change in weight	0	1	2	3	4

English (Universal) 16 November 2007

B9	I am able to feel like a woman	0	1	2	3	4
P2	I have certain parts of my body where I experience pain	0	1	2	3	4

English (Universal) 16 November 2007

WPAI:SHP

Work Productivity and Activity Impairment Questionnaire:

Specific Health Problem V2.0 (WPAI:SHP)

The following questions ask about the effect of your breast cancer on your ability to work and perform regular activities. *Please fill in the blanks or circle a number, as indicated.*

1. Are you currently employed (working for pay)? _____ NO ___ YES
   If NO, check "NO" and skip to question 6.

The next questions are about the **past seven days**, not including today.

2. During the past seven days, how many hours did you miss from work because of problems associated with your breast cancer? *Include hours you missed on sick days, times you went in late, left early, etc., because of your breast cancer. Do not include time you missed to participate in this study.*

   _____ HOURS

3. During the past seven days, how many hours did you miss from work because of any other reason, such as vacation, holidays, time off to participate in this study?

   _____HOURS

4. During the past seven days, how many hours did you actually work?

   _____HOURS *(If "0", skip to question 6.)*

5. During the past seven days, how much did your breast cancer affect your productivity while you were working?

Think about days you were limited in the amount or kind of work you could do, days you accomplished less than you would like, or days you could not do your work as carefully as usual. If breast cancer affected your work only a little, choose a low number. Choose a high number if breast cancer affected your work a great deal.

Consider only how much PROBLEM affected productivity while you were working.

Breast cancer had no effect on my work	0	1	2	3	4	5	6	7	8	9	10	Breast cancer completely prevented me from working

CIRCLE A NUMBER

6. During the past seven days, how much did your breast cancer affect your ability to do your regular daily activities, other than work at a job?

By regular activities, we mean the usual activities you do, such as work around the house, shopping, childcare, exercising, studying, etc. Think about times you were limited in the amount or kind of activities you could do and times you accomplished less than you would like. If breast cancer affected your activities only a little, choose a low number. Choose a high number if breast cancer affected your activities a great deal.

Consider only how much breast cancer affected your ability to do your regular daily activities, other than work at a job.

Breast cancer had no effect on my daily activities	0	1	2	3	4	5	6	7	8	9	10	Breast cancer completely prevented me from doing my daily activities

CIRCLE A NUMBER

WPAI:SHP V2.0 (US English)

Reilly MC, Zbrozek AS, Dukes E: The validity and reproducibility of a work productivity and activity impairment measure. PharmacoEconomics 1993; 4(5):353-365.

COST – FACIT (Version 2)

Below is a list of statements that other people with your illness have said are important**.**
Please circle or mark one number per line to indicate your response as it applies to the <u>past 7 days</u>.

		Not at all	A little bit	Some-what	Quite a bit	Very much
FT1	I know that I have enough money in savings, retirement, or assets to cover the costs of my treatment	0	1	2	3	4
FT2	My out-of-pocket medical expenses are more than I thought they would be	0	1	2	3	4
FT3	I worry about the financial problems I will have in the future as a result of my illness or treatment	0	1	2	3	4
FT4	I feel I have no choice about the amount of money I spend on care	0	1	2	3	4
FT5	I am frustrated that I cannot work or contribute as much as I usually do	0	1	2	3	4
FT6	I am satisfied with my current financial situation	0	1	2	3	4
FT7	I am able to meet my monthly expenses	0	1	2	3	4
FT8	I feel financially stressed	0	1	2	3	4
FT9	I am concerned about keeping my job and income, including work at home	0	1	2	3	4

FT10	My cancer or treatment has reduced my satisfaction with my present financial situation	0	1	2	3	4
FT11	I feel in control of my financial situation	0	1	2	3	4
FT12	My illness has been a financial hardship to my family and me	0	1	2	3	4

COSTS FOR PATIENTS QUESTIONNAIRE (COPAQ) (VERSION 1.0)

This protocol will use all Direct Non-Medical Costs Items relevant to Cancer in the CoPaQ Instrument. These items in the instrument are provided below. Please note when answering these questions: 1 mile = 1.6 kilometers.

Subject No: _____

Date: …-…-…

Code:_____

COSTS FOR PATIENTS QUESTIONNAIRE (CoPaQ)

Version_ 12_07_2022_Costs for Patients Questionnaire_ CoPaQ_Adapted for USA with permission from Maude Laberge, PhD

The purpose of this questionnaire is to assess your expenses as a result of your state of health. It is divided into three sections and should take you 10 to 15 minutes to complete. Some of the items may not apply to your situation. When answering, please only consider the period ranging from **…… to ……..**. All your information will remain confidential.

All listed costs or expenses must be associated with your health condition as it relates to your daily life or be directly linked with the use of health care services needed to treat your condition for the period ranging from **…… to ……..**.. You should only take into account the amounts you need to cover yourself, specifically the out-of-pocket cost. Do not include in your answers any portion of the costs reimbursed by your insurance. For some of the questions, you may have more than one answer.

Section A. Costs for Patients Questionnaire

1. Costs you need to cover (i.e., the out-of-pocket cost you have to pay and not the portion reimbursed by your insurer)

1.1. Did you travel to a health centre (e.g., hospital, family medicine group, physiotherapy clinic) to receive health care services or for consultations?

☐ Yes ☐ No

If no, please go to question 1.7.

1.2. What means of transportation did you use to get to the health centre or to your consultations?

☐ Public transit (bus, metro/subway)

☐ Taxi

☐ Personal vehicle

☐ Other means of transportation (e.g., on foot, by bicycle, personal vehicle of the person who went with you)

……

1.3. On average, how many miles (round trip) did you travel to get to and from the health centre or to your consultations? …… kilometre(s) per visit.
Number of visits during the reference period: ……

1.4. Did you pay for parking during your visits?

☐ Yes ☐ No

If yes, please provide the total number of visits and the out-of-pocket cost paid for all your parking needs: ……..…visit(s); $…….

1.5. On average, how much time did you spend in the clinic (including waiting time and consultation)? ……..hour(s)…….minutes

1.6. When travelling to the health center or to your consultations, did you pay for accommodation?

☐ Yes ☐ No

If yes, please provide the total number of visits and the out-of-pocket cost paid for all your accommodations: …….visit(s); $ ……..

1.7. Did you pay any portion "out-of-pocket" for your prescribed medication that was not reimbursed?

☐ Yes ☐ No

If yes, please provide the out-of-pocket cost paid: $……

1.8. Did you pay for non-prescribed medication or dietary supplements (e.g., aspirin, natural products)?

☐ Yes ☐ No

If yes, please provide the out-of-pocket cost paid: $……..

1.9. Did you incur expenses for home care services (e.g., rehabilitation)?

☐ Yes ☐ No

If yes, please provide the out-of-pocket cost paid: $..... Please provide the type of expenses……..

1.10. Did you incur expenses for the purchase of any medical devices (e.g., blood pressure monitor, blood glucose monitor, walker, wheelchair, raised toilet seat, protective underwear, shower rails)?

☐ Yes ☐ No

If yes, please provide the out-of-pocket cost paid: $……Please provide the type of expenses……..

1.11. Did you renovate your home in order to better accommodate your condition?

☐ Yes ☐ No

If yes, please provide the out-of-pocket cost paid: $…….

1.12. Did you pay for any tests or examinations performed during or following any of your consultations (e.g., blood tests, X-rays)?

☐ Yes ☐ No

If yes, please provide the out-of-pocket cost paid: $…….

1.13. Did you pay for any additional non-medical services during or following your consultations (e.g., insurance forms, sending photocopies, doctor's certificate)?

☐ Yes ☐ No

If yes, please provide the out-of-pocket cost paid: $…….

1.14. Did you pay for any non-medical care services (e.g., physiotherapy, occupational therapy, psychology, osteopathy, massage therapy, dentistry or optometry)?

☐ Yes ☐ No

If yes, please provide the out-of-pocket cost paid: $…….

1.15. Did you pay for someone to care for your dependents during any of your consultations (e.g., childcare or pet care)?

☐ Yes ☐ No

If yes, please provide the out-of-pocket cost paid: $…….

1.16. Did you incur other expenses (e.g., food services, any specific meals related to accessing health care services)?

☐ Yes ☐ No

If yes, please provide the out-of-pocket cost paid during this period: $……. Please provide the type of expenses……..

2. Average time spent (or required) to access medical services

2.1. How much time did you spend travelling to and from the health centre or to your consultations (round trip)? ..... hour(s)……..minutes

2.2. Approximately how much time did you spend booking medical services (e.g., over the phone or online, or to schedule an appointment at the clinic prior to your consultation)? ……..hour(s)…….minutes

3.0. Costs related to your job

3.1. Have you suffered a loss of income?

☐ Yes ☐ No

If no, please go to question 4.1.

If yes, for what reason? (List all that apply to you)

☐ Short- or long-term decrease in salary as a result of missing work

☐ As a result of receiving an employment insurance

☐ Reduced working hours per week (e.g., working 4 days/week)

☐ Limited career advancement or salary increase (e.g., cannot request or accept a promotion)

☐ Other (specify: ……)

3.2. What is your rough estimate (net amount) of the incurred loss of income for the period specified at the beginning of the questionnaire?

$ ☐ ☐ Difficult to evaluate

4. <u>Financial</u> stress caused by your state of health

4.1. I feel financially stressed due to my state of health:

☐ Not at all

☐ A little bit

☐ Somewhat

☐ Quite a bit

☐ Very much

5. <u>Out-of-pocket costs</u> for the caregiver (i.e., the person who regularly devotes time to help you with your daily activities) or the person who accompanies you, if any

5.1. Did a caregiver or anyone else accompany you to the health center or to your consultations?

☐ No, never

☐ Yes, sometimes

☐ Yes, half of the time

☐ Yes, very often

☐ Yes, all the time

If “No, never”, please go to section B.

5.2. Did you travel together to the health centre?

☐ Yes ☐ No

If yes, please go to question 5.5.

If no, please specify the means of transportation used by the caregiver or the person accompanying you.

☐ Public transit (bus, metro/subway)

☐ Taxi

☐ Personal vehicle

☐ Other means of transportation (e.g., on foot, by bicycle, personal vehicle of the person you are accompanying)

……

5.3. On average, how much time and how many miles (round trip) did this person travel to get to and from the health centre for each one of your visits?

……hour(s)……minutes ……kilometre(s)

5.4. Did this person pay for parking?

☐ Yes ☐ No ☐ I do not know

If yes, please provide the out-of-pocket cost paid: $…….

5.5. Did the caregiver or the person accompanying you to the health center or to your consultations need to pay for any accommodations?

☐ Yes ☐ No

If yes, please provide the out-of-pocket cost paid: $…….

5.6. Did your caregiver or the person accompanying you receive any training in order to assist you?

☐ Yes ☐ No ☐ I do not know

If yes, please provide the out-of-pocket cost paid: $…… and the duration of the training ……hour(s)…….minutes

5.7. Did your caregiver or the person accompanying you incur any other expenses while accompanying you?

☐ Yes ☐ No ☐ I do not know

If yes, please provide the out-of-pocket cost paid: $……Please provide the type of expenses……..

5.8. How long is the estimated waiting time experienced by your caregiver or the person accompanying you during your medical consultations? ……..hour(s)…….minutes

6. Time spent by your caregiver or the person accompanying you not directly related to medical services

6.1. Approximately how much time in total (round trip) do you estimate your caregiver or the person accompanying you spent travelling with you to get to and from your non-medical consultations (e.g., massage therapy, chirotherapy, naturopath)?
……..hour(s)…….minutes

6.2. How long is the estimated waiting time experienced by your caregiver or the person accompanying you during your non-medical consultations (e.g., massage therapy, chirotherapy, naturopath)?
……..hour(s)…….minutes

6.3. What is the estimated average time per week your caregiver or the person accompanying you spends performing various tasks (e.g., housework, home care)?
……..hour(s)…….minutes per week

Section B. Sociodemographic and Health Questions

1. Are you:

☐ Male ☐ Female
☐ Other……. ☐ Prefer not to say

2. Highest level of education completed:

☐ ≤ High School

☐ Some College

☐ College Grad or More

3. Do you have a paid job?

☐ Yes ☐ No

If not, which of the following best describes your situation?

☐ I cannot work at a paid job because of health problems. (If you had a paid job before, please specify your occupation and the position you held: Occupation …… ... ……period ranging from …….to……..)

☐ Other reasons (e.g., looking for work, unpaid job, retired)

4. Are you:

☐ Married ☐ Separated

☐ Living common law ☐ Divorced

☐ Never married (not living common law) ☐ Widowed

5. How many people live in your household?

☐ I live alone ☐ I live with one or more individuals

6. Are there any children in your household?

☐ Yes, the age of the youngest child living in the household is…….. months/years

☐ No

7. Do you live in a rural or urban area?

☐ Rural area ☐ Urban area

8. What is your approximate <u>gross annual income</u>? Check the income category that applies to you.

☐ < $5,000	☐ $25,000-29,999	☐ $50,000-59,999	☐ $90,000-99,999
☐ $5,000-9,999	☐ $30,000-34,999	☐ $60,000-69,999	☐ $100,000-124,999
☐ $10,000-14,999	☐ $35,000-39,999	☐ $70,000-79,999	☐ $125,000-149,999
☐ $15,000-19,999	☐ $40,000-44,999	☐ $80,000-89,999	☐ ≥ $150,000
☐ $20,000-24,999	☐ $45,000-49,999		

9. What is your age group? Check the group that applies to you.

☐ 18-24 years	☐ 55-64 years
☐ 25-34 years	☐ 65-74 years
☐ 35-44 years	☐ 75-84 years
☐ 45-54 years	☐ 85 years or more

10. We now suggest that you complete the EQ-5D-5L questionnaire.

Note to researchers: the EQ-5D-5L questionnaire measures various aspects of health-related quality of life and is available upon request at: https://euroqol.org/eq-5d-registration-form/

Section C. Acknowledgements and Comments Page

Thank you for completing this questionnaire. If you have any comments, please provide them below.

STAFF-ADMINISTERED VICC QUESTIONNAIRE

(Site staff may use this sheet for assistance in completing the Health Care Utilization CRFs in Rave)

Cycle: _____ Participant ID: _____

Time point *(check one)*
- ☐ Baseline (within 2 weeks of registration)
- ☐ 12 Weeks (since registration)
- ☐ 27 Weeks (since 12 weeks)

Was the patient seen by a medical provider during this timepoint? *(check one. If yes, fill out section below.)*

☐Yes ☐No

Were prescription medications taken orally or infused/injected during this timepoint (not including pembrolizumab)? *(check one. If yes, fill out Prescription Medication section on p.10.)*

☐Yes ☐No

Instances of Use of Care During This Time Point

Complete one entry for each time patient made use of heath care services during this time point. For each instance of use of care, check which site of care and provider(s) were used.

☐ Instance of Use of Care 1

Instance of Use of Care Date (month and year required): _____

Primary Reason for Visit/Communication: _____

- **Site of Care** *(check one)*

  ☐ Hospital Outpatient Department ☐ Emergency Department

  ☐ Provider's Office ☐ Skilled Nursing Facility/Rehab Facility

  ☐ Urgent Care Center ☐ Community Health Center ☐ Telemedicine

  ☐ Hospital Inpatient Department ☐ Intensive Care Unit (ICU) Hospital Inpatient Department

  ☐ Other Provider Type (please specify): _____

- **Provider Seen During this Instance of Use of Care:**

  ☐ Hematologist/oncologist ☐ Internal Medicine/Family Medicine/General Practitioner

  ☐ Emergency Physician ☐ Nurse Practitioner (NP)

  ☐ Physician Assistant (PA) ☐ Other Provider Type *(please specify):* _____

- **Were you hospitalized? (check one)**

  ☐Yes ☐No

  If yes, date of admission (month and year required): _____

- **Was blood drawn or was urine collected? (check one)**

  ☐Yes ☐No

- **Were imaging tests performed? *(check one)***

  ☐Yes ☐No

  If yes, specify site (body part) of imaging: _____

- Approximately how much did you pay "out-of-pocket" for this instance of use of a site of care that was not reimbursed by your insurance during this time point?

  _____

☐ Instance of Use of Care 2

Instance of Use of Care Date (month and year required): _____

Primary Reason for Visit/Communication: _____

- **Site of Care** *(check one)*

  ☐ Hospital Outpatient Department ☐ Emergency Department

  ☐ Provider's Office ☐ Skilled Nursing Facility/Rehab Facility

  ☐ Urgent Care Center ☐ Community Health Center ☐ Telemedicine

  ☐ Hospital Inpatient Department ☐ Intensive Care Unit (ICU) Hospital Inpatient Department

  ☐ Other Provider Type (please specify): _____

- **Provider Seen During this Instance of Use of Care:**

  ☐ Hematologist/oncologist ☐ Internal Medicine/Family Medicine/General Practitioner

  ☐ Emergency Physician ☐ Nurse Practitioner (NP)

  ☐ Physician Assistant (PA) ☐ Other Provider Type *(please specify):* _____

- **Were you hospitalized? (check one)**
  ☐Yes ☐No

  If yes, date of admission (month and year required): _____

- **Was blood drawn or was urine collected? (check one)**

  ☐Yes ☐No

- **Were imaging tests performed? *(check one)***

  ☐Yes ☐No

  If yes, specify site (body part) of imaging: _____

- Approximately how much did you pay "out-of-pocket" for this instance of use of a site of care that was not reimbursed by your insurance during this time point?

  _____

☐ Instance of Use of Care 3

Instance of Use of Care Date (month and year required): _____

Primary Reason for Visit/Communication: _____

- **Site of Care** *(check one)*

  ☐ Hospital Outpatient Department ☐ Emergency Department

  ☐ Provider's Office ☐ Skilled Nursing Facility/Rehab Facility

  ☐ Urgent Care Center ☐ Community Health Center ☐ Telemedicine

  ☐ Hospital Inpatient Department ☐ Intensive Care Unit (ICU) Hospital Inpatient Department

  ☐ Other Provider Type (please specify): _____

- **Provider Seen During this Instance of Use of Care:**

  ☐ Hematologist/oncologist ☐ Internal Medicine/Family Medicine/General Practitioner

  ☐ Emergency Physician ☐ Nurse Practitioner (NP)

  ☐ Physician Assistant (PA) ☐ Other Provider Type *(please specify):* _____

- **Were you hospitalized? (check one)**
  ☐Yes ☐No

  If yes, date of admission (month and year required): _____

- **Was blood drawn or was urine collected? (check one)**

  ☐Yes ☐No

- **Were imaging tests performed?** ***(check one)***

  ☐Yes ☐No

  If yes, specify site (body part) of imaging: _____

- Approximately how much did you pay "out-of-pocket" for this instance of use of a site of care that was not reimbursed by your insurance during this time point?

  _____

☐ Instance of Use of Care 4

Instance of Use of Care Date (month and year required): _____

Primary Reason for Visit/Communication: _____

- **Site of Care** *(check one)*

  ☐ Hospital Outpatient Department ☐ Emergency Department

  ☐ Provider's Office ☐ Skilled Nursing Facility/Rehab Facility

  ☐ Urgent Care Center ☐ Community Health Center ☐ Telemedicine

  ☐ Hospital Inpatient Department ☐ Intensive Care Unit (ICU) Hospital Inpatient Department

  ☐ Other Provider Type (please specify): _____

- **Provider Seen During this Instance of Use of Care:**

  ☐ Hematologist/oncologist ☐ Internal Medicine/Family Medicine/General Practitioner

  ☐ Emergency Physician ☐ Nurse Practitioner (NP)

  ☐ Physician Assistant (PA) ☐ Other Provider Type *(please specify):* _____

- **Were you hospitalized? (check one)**
  ☐Yes ☐No

  If yes, date of admission (month and year required): _____

- **Was blood drawn or was urine collected? (check one)**

  ☐Yes ☐No

- **Were imaging tests performed?** ***(check one)***

  ☐Yes ☐No

  If yes, specify site (body part) of imaging: _____

- Approximately how much did you pay "out-of-pocket" for this instance of use of a site of care that was not reimbursed by your insurance during this time point?

  _____

☐ Instance of Use of Care 5

Instance of Use of Care Date (month and year required): _____

Primary Reason for Visit/Communication: _____

- **Site of Care** *(check one)*

  ☐ Hospital Outpatient Department ☐ Emergency Department

  ☐ Provider's Office ☐ Skilled Nursing Facility/Rehab Facility

  ☐ Urgent Care Center ☐ Community Health Center ☐ Telemedicine

  ☐ Hospital Inpatient Department ☐ Intensive Care Unit (ICU) Hospital Inpatient Department

  ☐ Other Provider Type (please specify): _____

- **Provider Seen During this Instance of Use of Care:**

  ☐ Hematologist/oncologist ☐ Internal Medicine/Family Medicine/General Practitioner

  ☐ Emergency Physician ☐ Nurse Practitioner (NP)

  ☐ Physician Assistant (PA) ☐ Other Provider Type *(please specify):* _____

- **Were you hospitalized? (check one)**
  ☐Yes ☐No

  If yes, date of admission (month and year required): _____

- **Was blood drawn or was urine collected? (check one)**

  ☐Yes ☐No

- **Were imaging tests performed? *(check one)***

  ☐Yes ☐No

  If yes, specify site (body part) of imaging: _____

- Approximately how much did you pay "out-of-pocket" for this instance of use of a site of care that was not reimbursed by your insurance during this time point?

  _____

☐ Instance of Use of Care 6

Instance of Use of Care Date (month and year required): _____

Primary Reason for Visit/Communication: _____

- **Site of Care** *(check one)*

  ☐ Hospital Outpatient Department ☐ Emergency Department

  ☐ Provider's Office ☐ Skilled Nursing Facility/Rehab Facility

  ☐ Urgent Care Center ☐ Community Health Center ☐ Telemedicine

  ☐ Hospital Inpatient Department ☐ Intensive Care Unit (ICU) Hospital Inpatient Department

  ☐ Other Provider Type (please specify): _____

- **Provider Seen During this Instance of Use of Care:**

  ☐ Hematologist/oncologist ☐ Internal Medicine/Family Medicine/General Practitioner

  ☐ Emergency Physician ☐ Nurse Practitioner (NP)

  ☐ Physician Assistant (PA) ☐ Other Provider Type *(please specify):* _____

- **Were you hospitalized? (check one)**
  ☐Yes ☐No

  If yes, date of admission (month and year required): _____

- **Was blood drawn or was urine collected? (check one)**

  ☐Yes ☐No

- **Were imaging tests performed? *(check one)***

  ☐Yes ☐No

  If yes, specify site (body part) of imaging: _____

- Approximately how much did you pay "out-of-pocket" for this instance of use of a site of care that was not reimbursed by your insurance during this time point?

  _____

☐ Instance of Use of Care 7

Instance of Use of Care Date (month and year required): _____

Primary Reason for Visit/Communication: _____

- **Site of Care** *(check one)*

  ☐ Hospital Outpatient Department ☐ Emergency Department

  ☐ Provider's Office ☐ Skilled Nursing Facility/Rehab Facility

  ☐ Urgent Care Center ☐ Community Health Center ☐ Telemedicine

  ☐ Hospital Inpatient Department ☐ Intensive Care Unit (ICU) Hospital Inpatient Department

  ☐ Other Provider Type (please specify): _____

- **Provider Seen During this Instance of Use of Care:**

  ☐ Hematologist/oncologist ☐ Internal Medicine/Family Medicine/General Practitioner

  ☐ Emergency Physician ☐ Nurse Practitioner (NP)

  ☐ Physician Assistant (PA) ☐ Other Provider Type *(please specify):* _____

- **Were you hospitalized? (check one)**
  ☐Yes ☐No

  If yes, date of admission (month and year required): _____

- **Was blood drawn or was urine collected? (check one)**

  ☐Yes ☐No

- **Were imaging tests performed? *(check one)***

  ☐Yes ☐No

  If yes, specify site (body part) of imaging: _____

- Approximately how much did you pay "out-of-pocket" for this instance of use of a site of care that was not reimbursed by your insurance during this time point?

  _____

☐ Instance of Use of Care 8

Instance of Use of Care Date (month and year required): _____

Primary Reason for Visit/Communication: _____

- **Site of Care** *(check one)*

  ☐ Hospital Outpatient Department ☐ Emergency Department

  ☐ Provider's Office ☐ Skilled Nursing Facility/Rehab Facility

  ☐ Urgent Care Center ☐ Community Health Center ☐ Telemedicine

  ☐ Hospital Inpatient Department ☐ Intensive Care Unit (ICU) Hospital Inpatient Department

  ☐ Other Provider Type (please specify): _____

- **Provider Seen During this Instance of Use of Care:**

  ☐ Hematologist/oncologist ☐ Internal Medicine/Family Medicine/General Practitioner

  ☐ Emergency Physician ☐ Nurse Practitioner (NP)

  ☐ Physician Assistant (PA) ☐ Other Provider Type *(please specify):* _____

- **Were you hospitalized? (check one)**
  ☐Yes ☐No

  If yes, date of admission (month and year required): _____

- **Was blood drawn or was urine collected? (check one)**

  ☐Yes ☐No

- **Were imaging tests performed?** ***(check one)***

  ☐Yes ☐No

  If yes, specify site (body part) of imaging: _____

- Approximately how much did you pay "out-of-pocket" for this instance of use of a site of care that was not reimbursed by your insurance during this time point?

  _____

☐ Instance of Use of Care 9

Instance of Use of Care Date (month and year required): _____

Primary Reason for Visit/Communication: _____

- **Site of Care** *(check one)*

  ☐ Hospital Outpatient Department ☐ Emergency Department

  ☐ Provider's Office ☐ Skilled Nursing Facility/Rehab Facility

  ☐ Urgent Care Center ☐ Community Health Center ☐ Telemedicine

  ☐ Hospital Inpatient Department ☐ Intensive Care Unit (ICU) Hospital Inpatient Department

  ☐ Other Provider Type (please specify): _____

- **Provider Seen During this Instance of Use of Care:**

  ☐ Hematologist/oncologist ☐ Internal Medicine/Family Medicine/General Practitioner

  ☐ Emergency Physician ☐ Nurse Practitioner (NP)

  ☐ Physician Assistant (PA) ☐ Other Provider Type *(please specify):* _____

- **Were you hospitalized? (check one)**
  ☐Yes ☐No

  If yes, date of admission (month and year required): _____

- **Was blood drawn or was urine collected? (check one)**

  ☐Yes ☐No

- **Were imaging tests performed?** ***(check one)***

  ☐Yes ☐No

  If yes, specify site (body part) of imaging: _____

- Approximately how much did you pay "out-of-pocket" for this instance of use of a site of care that was not reimbursed by your insurance during this time point?

  _____

☐ Instance of Use of Care 10

Instance of Use of Care Date (month and year required): _____

Primary Reason for Visit/Communication: _____

- **Site of Care** *(check one)*

  ☐ Hospital Outpatient Department ☐ Emergency Department

  ☐ Provider's Office ☐ Skilled Nursing Facility/Rehab Facility

  ☐ Urgent Care Center ☐ Community Health Center ☐ Telemedicine

  ☐ Hospital Inpatient Department ☐ Intensive Care Unit (ICU) Hospital Inpatient Department

  ☐ Other Provider Type (please specify): _____

- **Provider Seen During this Instance of Use of Care:**

  ☐ Hematologist/oncologist ☐ Internal Medicine/Family Medicine/General Practitioner

  ☐ Emergency Physician ☐ Nurse Practitioner (NP)

  ☐ Physician Assistant (PA) ☐ Other Provider Type *(please specify):* _____

- **Were you hospitalized? (check one)**
  ☐Yes ☐No

  If yes, date of admission (month and year required): _____

- **Was blood drawn or was urine collected? (check one)**

  ☐Yes ☐No

- **Were imaging tests performed? *(check one)***

  ☐Yes ☐No

  If yes, specify site (body part) of imaging: _____

- Approximately how much did you pay "out-of-pocket" for this instance of use of a site of care that was not reimbursed by your insurance during this time point?

  _____

Prescription Medication (Oral or Injected/Infused) Received During this Time Point

Medication 1: _____

Frequency of medication use *(check one):*

☐ One time only
☐ Once daily
☐ 2 times daily
☐ 3 times daily
☐ Weekly
☐ Every 2 weeks
☐ Monthly
☐ As needed
☐ Other *(please specify)*: _____

Duration of medication use *(check one)*

☐ Once
☐ A month or less
☐ Continuous
☐ As needed
☐ Other *(please specify)*: _____

Approximately how much did you pay "out-of-pocket" for this prescription medication not reimbursed by your insurance during this timepoint? _____

Medication 2: _____

Frequency of medication use *(check one):*

☐ One time only
☐ Once daily
☐ 2 times daily
☐ 3 times daily
☐ Weekly
☐ Every 2 weeks
☐ Monthly
☐ As needed
☐ Other *(please specify)*: _____

Duration of medication use *(check one)*

☐ Once

☐ A month or less

☐ Continuous

☐ As needed

☐ Other *(please specify)*: _____

Approximately how much did you pay "out-of-pocket" for this prescription medication not reimbursed by your insurance during this timepoint? _____

Medication 3: _____

Frequency of medication use *(check one):*

☐ One time only

☐ Once daily

☐ 2 times daily

☐ 3 times daily

☐ Weekly

☐ Every 2 weeks

☐ Monthly

☐ As needed

☐ Other *(please specify)*: _____

Duration of medication use *(check one)*

☐ Once

☐ A month or less

☐ Continuous

☐ As needed

☐ Other *(please specify)*: _____

Approximately how much did you pay "out-of-pocket" for this prescription medication not reimbursed by your insurance during this timepoint? _____

Medication 4: _____

Frequency of medication use *(check one):*

☐ One time only

☐ Once daily

☐ 2 times daily
☐ 3 times daily
☐ Weekly
☐ Every 2 weeks
☐ Monthly
☐ As needed
☐ Other *(please specify)*: _____

Duration of medication use *(check one)*
☐ Once
☐ A month or less
☐ Continuous
☐ As needed
☐ Other *(please specify)*: _____
Approximately how much did you pay "out-of-pocket" for this prescription medication not reimbursed by your insurance during this timepoint? _____

Medication 5: _____
Frequency of medication use *(check one):*
☐ One time only
☐ Once daily
☐ 2 times daily
☐ 3 times daily
☐ Weekly
☐ Every 2 weeks
☐ Monthly
☐ As needed
☐ Other *(please specify)*: _____

Duration of medication use *(check one)*
☐ Once
☐ A month or less
☐ Continuous
☐ As needed

☐ Other *(please specify)*: _____

Approximately how much did you pay "out-of-pocket" for this prescription medication not reimbursed by your insurance during this timepoint? _____

Medication 6: _____

Frequency of medication use *(check one):*

☐ One time only
☐ Once daily
☐ 2 times daily
☐ 3 times daily
☐ Weekly
☐ Every 2 weeks
☐ Monthly
☐ As needed
☐ Other *(please specify)*: _____

Duration of medication use *(check one)*

☐ Once
☐ A month or less
☐ Continuous
☐ As needed
☐ Other *(please specify)*: _____

Approximately how much did you pay "out-of-pocket" for this prescription medication not reimbursed by your insurance during this timepoint? _____

Medication 7: _____

Frequency of medication use *(check one):*

☐ One time only
☐ Once daily
☐ 2 times daily
☐ 3 times daily
☐ Weekly
☐ Every 2 weeks
☐ Monthly
☐ As needed

☐ Other *(please specify)*: _____

Duration of medication use *(check one)*

☐ Once

☐ A month or less

☐ Continuous

☐ As needed

☐ Other *(please specify)*: _____

Approximately how much did you pay "out-of-pocket" for this prescription medication not reimbursed by your insurance during this timepoint? _____

Medication 8: _____

Frequency of medication use *(check one):*

☐ One time only

☐ Once daily

☐ 2 times daily

☐ 3 times daily

☐ Weekly

☐ Every 2 weeks

☐ Monthly

☐ As needed

☐ Other *(please specify)*: _____

Duration of medication use *(check one)*

☐ Once

☐ A month or less

☐ Continuous

☐ As needed

☐ Other *(please specify)*: _____

Approximately how much did you pay "out-of-pocket" for this prescription medication not reimbursed by your insurance during this timepoint? _____

Comments: _____

_____