Appendix 2
(Part 2-Prospective Survey)

## Patient information and assent

Dear Sir \ Madam,

We would be grateful if you would participate in our survey on how patients feel after surgery. The aim of the survey is to improve management of pain after live donor surgery.

The information you provide will be made anonymous once you hand in this questionnaire. This means that your name or other form of identification will be deleted from the questionnaire after you hand it in and will not be included in any records we will have.

Your answers in this questionnaire will not be shared with your medical or nursing team.

We can assure you that your team will treat you in the same way whether or not you choose to participate in our survey.

Many thanks for considering to take part in this survey.

Date of Survey ___________

Patient A2ALL code: ___________

Type of Pain Management (check all that apply)

- Epidural
- Intrathecal
- IVPCA
- Local Infiltration
- Other _________________

Signature of person administering survey ___________________

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The following questions are about pain you experienced during the last 24 hours.

P1. On this scale, please indicate the **least** pain you had in the first 24 hours:

0 1 2 3 4 5 6 7 8 9 10
no pain — worst pain possible

P1a. On this scale, please indicate the **least** pain you had in the last 24 hours:

0 1 2 3 4 5 6 7 8 9 10
no pain — worst pain possible

P2. On this scale, please indicate the **worst** pain you had in the last 24 hours:

0 1 2 3 4 5 6 7 8 9 10
no pain — worst pain possible

P3. How often were you in **severe** pain in the last 24 hours?

Please circle your best estimate of the percentage of time you experienced severe pain:

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%
never in severe pain — always in severe pain

P4. Circle the one number below that best describes how much pain **interfered or prevented you from**:

a. Doing **activities in bed** such as turning, sitting up, repositioning**:**

0 1 2 3 4 5 6 7 8 9 10
does not interfere — completely interferes

b. Doing **activities out of bed** such as walking, sitting in a chair, standing at the sink:

0 1 2 3 4 5 6 7 8 9 10
does not interfere — completely interferes

c. ***Falling* asleep**

0 1 2 3 4 5 6 7 8 9 10
does not interfere — completely interferes

d. ***Staying* asleep**

0 1 2 3 4 5 6 7 8 9 10
does not interfere — completely interferes

P5. Pain can affect our mood and emotions.
On this scale, please circle the **one** number that best shows how much the pain caused you to feel:

a. **Anxious** 0 1 2 3 4 5 6 7 8 9 10
not at all — extremely

b. **Depressed** 0 1 2 3 4 5 6 7 8 9 10
not at all — extremely

c. **Frightened** 0 1 2 3 4 5 6 7 8 9 10
not at all — extremely

d. **Helpless** 0 1 2 3 4 5 6 7 8 9 10

Signature of person administering survey ___________________

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not at all extremely

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P6. Have you had any of the following side effects?
Please circle "0" if no; if yes, circle the **one** number that best shows the severity of each:

| | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| a. Nausea | 0 none | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 severe |
| b. Drowsiness | 0 none | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 severe |
| c. Itching | 0 none | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 severe |
| d. Dizziness | 0 none | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 severe |

P7. In the last 24 hours, how much pain **relief** have you received?
Please circle the one percentage that best shows how much relief you have received from all of your pain treatments combined (medicine and non-medicine treatments):

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%
no relief complete relief

P8. Were you **allowed to participate in decisions** about your pain treatment as much as you wanted to?

0 1 2 3 4 5 6 7 8 9 10
not at all very much so

P9. Circle the one number that best shows how **satisfied** you are with the results of your pain treatment while in the hospital:

0 1 2 3 4 5 6 7 8 9 10
extremely dissatisfied extremely satisfied

P10. Did you receive any **information** about your pain treatment options? ___ No, ___ Yes.
a. If yes, please circle the number that best shows **how helpful** the information was:

0 1 2 3 4 5 6 7 8 9 10
not at all helpful extremely helpful

P11. Did you use any **non-medicine methods** to relieve your pain? _____ No _____ Yes.
If yes, **check all** that apply:

_____ cold pack
_____ deep breathing
_____ distraction (such as watching TV, reading)
_____ heat
_____ imagery or visualization
_____ massage
_____ meditation
_____ listen to music
_____ prayer
_____ relaxation
_____ walking
other (please describe)
________________________________

P12. How often did a nurse or doctor **encourage you to use** non-medicine methods?
_____ never _____ sometimes _____ often

**Thank you for your time and feedback**

Signature of person administering survey __________________