



Trinity College Dublin  
Coláiste na Tríonóide, Baile Átha Cliath  
The University of Dublin



# Wave 5 Pre-Interview Questionnaire: Confidential

## Intellectual Disability Supplement to The Irish Longitudinal Study on Ageing (IDS-TILDA)

IDS-TILDA ID NUMBER:

GENDER: FEMALE  MALE

### FOR OFFICE USE ONLY

INTERVIEW DATE:   /   /

INTERVIEWER ID NUMBER:

IDS-TILDA would like to convey to the reader that no part of this protocol may be replicated reproduced or copied in any form without the explicit permission of the principal investigator of IDS-TILDA ©



***IDS-TILDA***

***Working to Make Ireland the Best Place to  
Grow Old***

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## INSTRUCTIONS

Thank you for taking part in WAVE 5 of The Intellectual Disability Supplement to TILDA (IDS-TILDA). This pre-interview questionnaire is the first part of this study and we would like you to please fill it in before your interview. Your answers are very important to us to help ensure the needs of people with an intellectual disability are met as they grow older.

## HOW TO FILL IN THE QUESTIONNAIRE.

Please answer the questions by:

Ticking a box like this



Or writing a number in a box like this



Sometimes you will find an instruction telling you which questions to answer next like this

YES

NO

IF 'NO' GO TO QUESTION 3

## WHAT TO DO IF YOU NEED HELP.

If you need support filling in the questionnaire ask a family member, a key worker or a friend who knows you at least 6 months to help.

If you have any questions about the questionnaire, please call us on 01 8963187.

## HOW TO RETURN THIS QUESTIONNAIRE

Please give the questionnaire to the interviewer on the day of your interview. Or alternatively you can return it in the pre-paid envelope supplied. If you have any questions about the questionnaire, please call us on 01 8963187 or email us at [haighm@tcd.ie](mailto:haighm@tcd.ie)

## Personal Details – For New Participants only

**NP1:** Are you male or female?

Please tick one box only

Male	<input type="checkbox"/>
Female	<input type="checkbox"/>

**NP2:** What is your date of birth? (Day/month/year)

(e.g. 01/03/66)

		/			/		
--	--	---	--	--	---	--	--

Don't know

**NP3:** Are you ...?

Please tick one box only

Single (never married)	<input type="checkbox"/>
Living with a partner as if married	<input type="checkbox"/>
With a partner but not living with him/her	<input type="checkbox"/>
Married	<input type="checkbox"/>
Separated	<input type="checkbox"/>
Divorced	<input type="checkbox"/>
Widowed	<input type="checkbox"/>
Don't know	<input type="checkbox"/>

<p><b>NP4:</b></p>	<p><b>Do you have any children?</b></p> <p>Please tick one box only</p> <table border="1"> <tr> <td data-bbox="400 302 783 360">Yes</td> <td data-bbox="783 302 895 360"><input checked="" type="checkbox"/></td> </tr> <tr> <td data-bbox="400 360 783 418">No</td> <td data-bbox="783 360 895 418"><input type="checkbox"/></td> </tr> <tr> <td data-bbox="400 418 783 472">Don't know</td> <td data-bbox="783 418 895 472"><input checked="" type="checkbox"/></td> </tr> </table>	Yes	<input checked="" type="checkbox"/>	No	<input type="checkbox"/>	Don't know	<input checked="" type="checkbox"/>						
Yes	<input checked="" type="checkbox"/>												
No	<input type="checkbox"/>												
Don't know	<input checked="" type="checkbox"/>												
<p><b>NP5:</b></p>	<p><b>What is your level of intellectual disability?</b></p> <p>Please tick one box only</p> <table border="1"> <tr> <td data-bbox="400 633 783 714">Not verified</td> <td data-bbox="783 633 895 714"><input checked="" type="checkbox"/></td> </tr> <tr> <td data-bbox="400 714 783 795">Mild</td> <td data-bbox="783 714 895 795"><input type="checkbox"/></td> </tr> <tr> <td data-bbox="400 795 783 875">Moderate</td> <td data-bbox="783 795 895 875"><input checked="" type="checkbox"/></td> </tr> <tr> <td data-bbox="400 875 783 956">Severe</td> <td data-bbox="783 875 895 956"><input type="checkbox"/></td> </tr> <tr> <td data-bbox="400 956 783 1037">Profound</td> <td data-bbox="783 956 895 1037"><input checked="" type="checkbox"/></td> </tr> <tr> <td data-bbox="400 1037 783 1126">Don't know</td> <td data-bbox="783 1037 895 1126"><input type="checkbox"/></td> </tr> </table>	Not verified	<input checked="" type="checkbox"/>	Mild	<input type="checkbox"/>	Moderate	<input checked="" type="checkbox"/>	Severe	<input type="checkbox"/>	Profound	<input checked="" type="checkbox"/>	Don't know	<input type="checkbox"/>
Not verified	<input checked="" type="checkbox"/>												
Mild	<input type="checkbox"/>												
Moderate	<input checked="" type="checkbox"/>												
Severe	<input type="checkbox"/>												
Profound	<input checked="" type="checkbox"/>												
Don't know	<input type="checkbox"/>												
<p><b>NP6:</b></p>	<p><b>What is the cause of your intellectual disability?</b></p> <p>Please tick one box only</p> <table border="1"> <tr> <td data-bbox="400 1305 1150 1386">Down syndrome</td> <td data-bbox="1150 1305 1262 1386"><input checked="" type="checkbox"/></td> </tr> <tr> <td data-bbox="400 1386 1150 1467">Cause of intellectual disability not diagnosed</td> <td data-bbox="1150 1386 1262 1467"><input type="checkbox"/></td> </tr> <tr> <td data-bbox="400 1467 1150 1547">Don't know</td> <td data-bbox="1150 1467 1262 1547"><input checked="" type="checkbox"/></td> </tr> <tr> <td data-bbox="400 1547 1150 1628">Other</td> <td data-bbox="1150 1547 1262 1628"><input type="checkbox"/></td> </tr> </table> <p>Other (please tell us)</p> <div data-bbox="400 1740 1222 1906" style="border: 1px solid black; height: 74px; width: 515px;"></div>	Down syndrome	<input checked="" type="checkbox"/>	Cause of intellectual disability not diagnosed	<input type="checkbox"/>	Don't know	<input checked="" type="checkbox"/>	Other	<input type="checkbox"/>				
Down syndrome	<input checked="" type="checkbox"/>												
Cause of intellectual disability not diagnosed	<input type="checkbox"/>												
Don't know	<input checked="" type="checkbox"/>												
Other	<input type="checkbox"/>												

**NP7:**

**What is the highest level of education you have completed?**

Tick one box only

Some primary (not complete)	<input type="checkbox"/>
Primary or equivalent completed	<input type="checkbox"/>
Intermediate/junior/group certificate or equivalent	<input type="checkbox"/>
Leaving certificate or equivalent	<input type="checkbox"/>
Diploma/certificate	<input type="checkbox"/>
Primary degree	<input type="checkbox"/>
Postgraduate/higher degree	<input type="checkbox"/>
None	<input type="checkbox"/>
Don't know	<input type="checkbox"/>
Other	<input type="checkbox"/>

**Other (please tell us)**

**NP8:**

**How long have you lived in your current place of residence?**

year(s)      month(s)

Don't know

NP9:	Are you an active member of any of these organisations, clubs or societies? (Have attended within the last six months)			
	Within Community Setting	Within ID Service	Both within community & ID service	Don't know
Political party, trade union or environmental groups				
Tenants groups, resident groups, Neighbourhood Watch				
Church or religious groups				
Charitable associations (for example, St Vincent De Paul's)				
Arts or music				
Special Olympics Network				
Arch Club				
Advocacy Group				
Social, Sports or Leisure club				
Other (please specify)				
Not applicable – Not a member or any specialized, club or society				

(ELSA/IDS-TILDA)

## A) Section A: How you spend your free time

**Question 1: How often if at all, do you do any of the following activities**

**FOR EACH ACTIVITY TICK ONE BOX THAT APPLIES**

Activity	Daily/ Almost Daily	Once a week or more	Twice a month or more	About once a month	Every few months	About once or twice a year	Don't Know	Never
Go to cinema								
Theatre, Concert, Opera								
Eat Out								
Go to an art Gallery or museum								
Go to church or other place of worship								
Go to pub for a drink								
Go to a coffee shop for light refreshments								
Go Shopping								
Participates in sports activities								
Go to sports events								
Go to library								

FOR EACH ACTIVITY TICK ONE BOX THAT APPLIES



Activity	Daily/ Almost Daily	Once a week or more	Twice a month or more	About once a month	Every few months	About once or twice a year	Don't Know	Never
Go to social clubs (e.g. bingo, play cards)								
Go to Hairdressers								
Perform in local art groups and choirs								
Spend time on hobbies or creative activities								
Visit family and friends in their home								
Talk to family and friends on the telephone								
Do voluntary work								
Other activities outside of the home please specify								

**Question 2:** Thinking of the activities you ticked in question one, please let us know if you do these activities within the community setting, within an ID service setting or both settings

**FOR EACH ACTIVITY SELECTED ABOVE, TICK ONE BOX THAT APPLIES**



Activity	Within the community setting	Within ID Service Setting	Both within the community and ID setting	Don't Know	Never	Who supports you doing this activity?
Cinema						
Theatre, Concert or Opera						
Eat Out						
Go to an art Gallery or museum						
Go to church or other place of worship						
Go to a pub for a drink						
Go to a coffee shop for light refreshments						
Go Shopping						
Participates in sports activities						
Go to Sports events						
Go to Library						

<b>Activity</b>	<b>Within the community setting</b>	<b>Within ID Service Setting</b>	<b>Both within the community and ID setting</b>	<b>Don't Know</b>	<b>Never</b>	<b>Who supports you doing this activity?</b>
Go to social clubs (e.g. bingo, play cards)						
Go to the hairdressers						
Perform in local art groups and choirs						
Spend time on hobbies or creative activities						
Visit family and friends in their home						
Talk to family and friends on the telephone						
Do voluntary work						
Other activities outside of your home						

Other (Please Specify)

## B) Section B: Height and weight

**Question 3:**

**What is your height without shoes?**

Centimetres

**Or**

Feet

Inches

Don't know

**Question 4:**

**What is your weight without clothes?**

Stones

Pounds

(e.g. 10)

(e.g. 2)

**Or**

Pounds

(e.g. 142)

**Or**

Kilos

(e.g. 64.4)

Don't know

### C) Section C: Medical Tests and screening

**Question 5:**

Please indicate if you have received any of the following injections.

Please tick one box per line

	YES	NO	Don't know
A flu injection in the last year?			
A Hepatitis B Vaccine in the last 5 years?			
A COVID-19 vaccine?			
A COVID-19 booster vaccine?			

**Question 6:**

Please indicate if you have received any of the following medical tests in the last two years.

Please tick one box per line

	YES, within the last 2 years	NO	Don't Know
A blood test for cholesterol?			
Your blood pressure measured?			
A thyroid function test?			
A blood glucose test (sugar test)?			
Been screened or assessed from memory impairment / Dementia?			
A bone density test? (e.g. DXA scan)			
A bowel cancer screening test?			
A PSA blood test (men only)?			

	COVID-19 test																									
<b>Question 6a:</b>	<p>If you were tested for COVID-19, did you ever test positive?</p> <p>Please tick one box only</p> <table border="1"> <tr> <td>Yes, positive antigen test</td> <td></td> </tr> <tr> <td>Yes, positive PCR test</td> <td></td> </tr> <tr> <td>Yes, positive antigen and PCT test</td> <td></td> </tr> <tr> <td>Yes, unsure which test</td> <td></td> </tr> <tr> <td>No</td> <td></td> </tr> <tr> <td>Don't know</td> <td></td> </tr> </table>				Yes, positive antigen test		Yes, positive PCR test		Yes, positive antigen and PCT test		Yes, unsure which test		No		Don't know											
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Yes, positive PCR test																										
Yes, positive antigen and PCT test																										
Yes, unsure which test																										
No																										
Don't know																										
<b>Question 6b:</b>	<p>If you tested positive, how long did the symptoms last for? (If you tested positive more than once, please indicate the length of symptoms that lasted the longest):</p> <p>Please ✓ one box only</p> <table border="1"> <tr> <td>Less than a week</td> <td></td> </tr> <tr> <td>1-2 weeks</td> <td></td> </tr> <tr> <td>3-4 weeks</td> <td></td> </tr> <tr> <td>4-5 weeks</td> <td></td> </tr> <tr> <td>6-8 weeks</td> <td></td> </tr> <tr> <td>9-11 weeks</td> <td></td> </tr> <tr> <td>12 weeks or more</td> <td></td> </tr> <tr> <td>I haven't recovered, and symptoms have lasted for 12 weeks or less</td> <td></td> </tr> <tr> <td>I haven't recovered, and symptoms have lasted for longer than 12 weeks</td> <td></td> </tr> <tr> <td>N/A: had no symptoms</td> <td></td> </tr> <tr> <td>Don't know</td> <td></td> </tr> </table>				Less than a week		1-2 weeks		3-4 weeks		4-5 weeks		6-8 weeks		9-11 weeks		12 weeks or more		I haven't recovered, and symptoms have lasted for 12 weeks or less		I haven't recovered, and symptoms have lasted for longer than 12 weeks		N/A: had no symptoms		Don't know	
Less than a week																										
1-2 weeks																										
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I haven't recovered, and symptoms have lasted for 12 weeks or less																										
I haven't recovered, and symptoms have lasted for longer than 12 weeks																										
N/A: had no symptoms																										
Don't know																										
<b>Question 6c:</b>	<p>If you had any effects of COVID-19 that were present more than 12 weeks after you got COVID-19, what were they?</p> <p>Please ✓ all that apply:</p>																									

Fever	
Chills	
Cough	
Shortness of breath or difficulty breathing	
Aches and pains	
Fatigue	
Headache	
Sore throat	
Feeling sick	
Vomiting	
Diarrhoea	
Loss of sense of smell	
Loss of sense of taste	
Confusion	
Disorientation	
Change in mood	
Change in behaviour/way [you/Rname] act(s)	
Change in memory or thinking/brain fog	
Congestion or runny nose	
Other	
Don't know	

**If other, please specify:**

**Question 6d:**

If you ever tested positive for COVID-19, did this happen after receiving a COVID-19 vaccine?

Please tick one box only

Yes	<input type="checkbox"/>
No	<input type="checkbox"/>
N/A (did not test positive)	<input type="checkbox"/>
Don't know	<input type="checkbox"/>

## D) Section D: Women only Questions



**Question 7a:** **As women get older (often between the ages of 45 & 55), they enter the menopause, are you aware of this?**

Menopause can be described as the time of life when a woman's ovaries stop producing hormones and menstrual periods stop. It is a natural part of ageing.

As women get older (often between the ages of 45 & 55), they enter the menopause, are you aware of this?

YES	
NO	
Don't Know	

**Question 7b:** **Have you gone through or are you currently going through the menopause?**

The first sign of going through menopause is usually a change in the normal pattern of a woman's periods.

A woman is considered to be post-menopausal or having gone through menopause when she hasn't had a period for 12 months in a row.

Please tick one box only

YES, gone through the menopause already		<b>Go to Q. 7c</b>
YES, currently going through the menopause		<b>Go to Q. 7c</b>
NO		<b>Go to Q. 7d</b>
Don't know		<b>Go to Q. 7d</b>

<b>Question 7c:</b>	<b>About how old were you when it started?</b>  I was <input type="text"/> <input type="text"/> years old  Don't know <input type="text"/>									
<b>Question 7d:</b>	<b>Have you discussed the menopause with someone?</b> Please tick only one <table border="1" data-bbox="389 645 1299 815"> <tr> <td>YES</td> <td><input type="checkbox"/></td> <td>Go to Q.7e</td> </tr> <tr> <td>NO</td> <td><input type="checkbox"/></td> <td>Go to Q.7f</td> </tr> <tr> <td>Don't Know</td> <td><input type="checkbox"/></td> <td>Go to Q.7f</td> </tr> </table>	YES	<input type="checkbox"/>	Go to Q.7e	NO	<input type="checkbox"/>	Go to Q.7f	Don't Know	<input type="checkbox"/>	Go to Q.7f
YES	<input type="checkbox"/>	Go to Q.7e								
NO	<input type="checkbox"/>	Go to Q.7f								
Don't Know	<input type="checkbox"/>	Go to Q.7f								
<b>Question 7e:</b>	<b>Who did you discuss menopause with?</b>  <input style="width: 100%; height: 50px;" type="text"/>									
<b>Question 7f:</b>	<b>Have you ever received any easy-to-read information materials about the menopause?</b>  <table border="1" data-bbox="389 1182 1027 1352"> <tr> <td>YES</td> <td><input type="checkbox"/></td> </tr> <tr> <td>NO</td> <td><input type="checkbox"/></td> </tr> <tr> <td>Don't Know</td> <td><input type="checkbox"/></td> </tr> </table>	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>	Don't Know	<input type="checkbox"/>			
YES	<input type="checkbox"/>									
NO	<input type="checkbox"/>									
Don't Know	<input type="checkbox"/>									
<b>Question 7g:</b>	<b>Did you know that some lifestyle factors can make menopausal symptoms worse e.g. smoking, alcohol intake, low calcium diet, high intake of caffeine)?</b>  <table border="1" data-bbox="389 1496 1027 1666"> <tr> <td>YES</td> <td><input type="checkbox"/></td> </tr> <tr> <td>NO</td> <td><input type="checkbox"/></td> </tr> <tr> <td>Don't Know</td> <td><input type="checkbox"/></td> </tr> </table>	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>	Don't Know	<input type="checkbox"/>			
YES	<input type="checkbox"/>									
NO	<input type="checkbox"/>									
Don't Know	<input type="checkbox"/>									
<b>Question 8:</b>	<b>Have you had any symptoms of menopause that you are aware of?</b>  <b>e.g. hot flushes, mood changes</b>									

	YES		Go To Q.8a
	NO		Go to Q.9
	Don't Know		Go to Q.9
<b>Question 8a:</b>	<b>Which symptoms have you had?</b>		
	Irregular periods		
	Hot flushes		
	Night sweats		
	Sleep problems		
	Mood changes		
	Anxiety		
	Problems with memory or concentration (brain fog)		
	Muscle aches and joint pains		
	Changed body shape/weight gain		
	Fatigue		
	Headaches		
	Heart palpitations		
	Recurring Urinary Tract Infections (UTIs)		
	Lack of energy		
	Loss of muscle		
	Other (please specify)		
<b>Question 9:</b>	<b>Have you been invited for a mammogram in the last 2 years?</b>		
	Please tick one box only		
	YES		Go To Q.10
	NO		Go to Q.12
	Don't Know		Go to Q.12

<b>Question 10:</b>	<p><b>If you were invited, did you attend?</b></p> <p>Please tick one box only</p> <table border="1" data-bbox="389 356 1294 528"> <tr> <td>YES</td> <td></td> <td>Go To Q.12</td> </tr> <tr> <td>NO</td> <td></td> <td>Go to Q.11</td> </tr> <tr> <td>Don't Know</td> <td></td> <td>Go to Q.12</td> </tr> </table>	YES		Go To Q.12	NO		Go to Q.11	Don't Know		Go to Q.12							
YES		Go To Q.12															
NO		Go to Q.11															
Don't Know		Go to Q.12															
<b>Question 11:</b>	<p><b>If you did not attend, what was the reason?</b></p> <p>Please tick all that apply</p> <table border="1" data-bbox="389 710 1385 1384"> <tr> <td>Environment not accessible e.g. the machine not suitable, no wheelchair access</td> <td></td> </tr> <tr> <td>Lack of support staff</td> <td></td> </tr> <tr> <td>Lack of transport</td> <td></td> </tr> <tr> <td>Too long in the waiting room</td> <td></td> </tr> <tr> <td>Fear</td> <td></td> </tr> <tr> <td>Cost</td> <td></td> </tr> <tr> <td>Don't know</td> <td></td> </tr> <tr> <td>Other (Please specify)</td> <td></td> </tr> </table>	Environment not accessible e.g. the machine not suitable, no wheelchair access		Lack of support staff		Lack of transport		Too long in the waiting room		Fear		Cost		Don't know		Other (Please specify)	
Environment not accessible e.g. the machine not suitable, no wheelchair access																	
Lack of support staff																	
Lack of transport																	
Too long in the waiting room																	
Fear																	
Cost																	
Don't know																	
Other (Please specify)																	
<b>Question 12:</b>	<p><b>Have you been invited for a Cervical smear test in the last 2 years?</b></p> <p>Please tick one box only</p> <table border="1" data-bbox="389 1603 1299 1776"> <tr> <td>YES</td> <td></td> <td>Go To Q.13</td> </tr> <tr> <td>NO</td> <td></td> <td>Go to Q.15</td> </tr> <tr> <td>Don't Know</td> <td></td> <td>Go to Q.15</td> </tr> </table>	YES		Go To Q.13	NO		Go to Q.15	Don't Know		Go to Q.15							
YES		Go To Q.13															
NO		Go to Q.15															
Don't Know		Go to Q.15															

<b>Question 13:</b>	<p><b>If you were invited, did you attend?</b></p> <p>Please tick one box only</p> <table border="1"> <tr> <td data-bbox="387 356 874 409">YES</td> <td data-bbox="874 356 1007 409"></td> <td data-bbox="1007 356 1291 409"><b>Go To Q.15</b></td> </tr> <tr> <td data-bbox="387 409 874 468">NO</td> <td data-bbox="874 409 1007 468"></td> <td data-bbox="1007 409 1291 468"><b>Go to Q.14</b></td> </tr> <tr> <td data-bbox="387 468 874 526">Don't Know</td> <td data-bbox="874 468 1007 526"></td> <td data-bbox="1007 468 1291 526"><b>Go to Q.15</b></td> </tr> </table>	YES		<b>Go To Q.15</b>	NO		<b>Go to Q.14</b>	Don't Know		<b>Go to Q.15</b>									
YES		<b>Go To Q.15</b>																	
NO		<b>Go to Q.14</b>																	
Don't Know		<b>Go to Q.15</b>																	
<b>Question 14:</b>	<p><b>If you did not attend, what was the reason?</b></p> <p>Please tick all that apply</p> <table border="1"> <tr> <td data-bbox="387 761 1259 875">Environment not accessible e.g. the equipment not suitable, no wheelchair access</td> <td data-bbox="1259 761 1383 875"></td> </tr> <tr> <td data-bbox="387 875 1259 929">Lack of support staff</td> <td data-bbox="1259 875 1383 929"></td> </tr> <tr> <td data-bbox="387 929 1259 985">Lack of transport</td> <td data-bbox="1259 929 1383 985"></td> </tr> <tr> <td data-bbox="387 985 1259 1039">Too long in the waiting room</td> <td data-bbox="1259 985 1383 1039"></td> </tr> <tr> <td data-bbox="387 1039 1259 1095">Fear</td> <td data-bbox="1259 1039 1383 1095"></td> </tr> <tr> <td data-bbox="387 1095 1259 1149">Cost</td> <td data-bbox="1259 1095 1383 1149"></td> </tr> <tr> <td data-bbox="387 1149 1259 1205">No need</td> <td data-bbox="1259 1149 1383 1205"></td> </tr> <tr> <td data-bbox="387 1205 1259 1258">Don't know</td> <td data-bbox="1259 1205 1383 1258"></td> </tr> <tr> <td data-bbox="387 1258 1259 1489">Other (Please specify)</td> <td data-bbox="1259 1258 1383 1489"></td> </tr> </table>	Environment not accessible e.g. the equipment not suitable, no wheelchair access		Lack of support staff		Lack of transport		Too long in the waiting room		Fear		Cost		No need		Don't know		Other (Please specify)	
Environment not accessible e.g. the equipment not suitable, no wheelchair access																			
Lack of support staff																			
Lack of transport																			
Too long in the waiting room																			
Fear																			
Cost																			
No need																			
Don't know																			
Other (Please specify)																			

## E) Section E: Health Services You Use

**Question 15:** Are you covered by private medical insurance?

15:

Please tick one box only

YES, covered by private medical insurance	<input type="checkbox"/>
NO, not covered by private medical insurance	<input type="checkbox"/>
Don't know	<input type="checkbox"/>

**Question 16:** The next question is about the health services you use, where you use them, and how many times in the last year you attended. It also asks if you paid for any of the services out of your own pocket.

16:

Don't know if any health services used in the last year  **Go to Q. 17**

Didn't use any health services in the last year  **Go to Q. 17**

**If you did use any health services in the last year, tell us how many times you attended the health service in the community or in the service provider / service setting.**

**For any you didn't attend, please put a '0' in the relevant box.**

**Also please tell us if you paid for any of these visits out of your own pocket.**

ANSWER ALL THAT APPLY

		How many times did you attend in the community setting / mainstream?	How many times did you attend in the service provider setting?	Did you pay for any of these visits out of your own pocket? PLEASE TICK IF APPLICABLE 
General Practitioner (GP)	In-person			
	Remote (e.g. online/ phone)			
Public Health or community nurse	In-person			
	Remote			
Intellectual Disability Nurse/Clinical Nurse Specialist/ Advanced Nurse Practitioner	In-person			
	Remote			

	Occupational therapy	In-person			
		Remote			
	Chiropody services	In-person			
		Remote			
	Physiotherapy services	In-person			
		Remote			
	Social work services	In-person			
		Remote			
	Psychological / counselling services	In-person			
		Remote			
	Home Help	In-person			
		Remote			
	Optician services	In-person			
		Remote			
	Hearing services	In-person			
		Remote			
	Dental Services	In-person			
		Remote			
	Pharmacist	In-person			
		Remote			

	Dietician Services	In-person			
		Remote			
	Speech & Language services	In-person			
		Remote			
	Neurological services	In-person			
		Remote			
	Psychological services	In-person			
		Remote			
	Endocrinology services	In-person			
		Remote			
	Dermatology services	In-person			
		Remote			
	Palliative care services	In-person			
		Remote			
	Other	In-person			
		Remote			
<b>Question 16b:</b>	<b>'Did you feel anxious or worried attending any of the above health services?'</b>				
	Yes	<input type="checkbox"/>			
	No	<input type="checkbox"/>			

	<p>If Yes, which service did you feel anxious or worried about attending?</p> <div style="border: 1px solid black; height: 40px; width: 600px; margin: 10px 0;"></div>										
<p><b>Question 17:</b></p>	<p><b>In the last year, about how often did your GP visit you at home?</b></p> <p>Number of visits <input style="width: 40px; height: 25px;" type="text"/></p> <p>Don't know <input style="width: 40px; height: 25px;" type="text"/></p>										
<p><b>Question 18:</b></p>	<p><b>In the last year, how many times did you attend a hospital emergency department for treatment?</b></p> <p>Number of visits <input style="width: 40px; height: 25px;" type="text"/></p> <p>Don't know <input style="width: 40px; height: 25px;" type="text"/></p>										
<p><b>Question 19:</b></p>	<p><b>This question asks for more information about your visits to a hospital emergency department for treatment in the last year.</b></p> <p>Didn't visit a hospital emergency department <input style="width: 40px; height: 25px;" type="checkbox"/> <b>Go to Q. 20</b></p> <p>If you attended a hospital emergency department for treatment in the last year, what was the reason?</p> <p><b>Please tick all that applies</b></p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr style="background-color: #c8e6c9;"> <td style="padding: 5px;">Multiple injuries</td> <td style="width: 30px; text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td style="padding: 5px;">Broken or fractured bone(s)</td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr style="background-color: #c8e6c9;"> <td style="padding: 5px;">Burn(s)</td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td style="padding: 5px;">Dislocation(s)</td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr style="background-color: #c8e6c9;"> <td style="padding: 5px;">Sprain or strain(s)</td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> </table>	Multiple injuries	<input type="checkbox"/>	Broken or fractured bone(s)	<input type="checkbox"/>	Burn(s)	<input type="checkbox"/>	Dislocation(s)	<input type="checkbox"/>	Sprain or strain(s)	<input type="checkbox"/>
Multiple injuries	<input type="checkbox"/>										
Broken or fractured bone(s)	<input type="checkbox"/>										
Burn(s)	<input type="checkbox"/>										
Dislocation(s)	<input type="checkbox"/>										
Sprain or strain(s)	<input type="checkbox"/>										

	Cut(s) or Open wound(s)		
	Scrape, bruise, blister(s)		
	Concussion or other head/brain injury		
	Poisoning		
	Internal injuries(s)		
	Pneumonia		
	Epilepsy		
	Behavioural issues		
	COVID-19		
	As a result of crime-related event (e.g. being assaulted, robbed, or attacked)		
	Don't know		
	Other		

**Question 19a:** Following the visit to the emergency department were you:

**Please tick all that apply**

Admitted to hospital?	
Referred to a consultant?	
Referred to an outpatient department?	
Referred to your GP?	
No follow-up	
Don't know	
Other, please specify	

(TILDA)

<b>Question 20:</b>	<p><b>In the last year, about how many visits did you make to a hospital outpatient clinic?</b></p> <p>Number of visits <input type="text"/></p> <p>Don't know <input type="text"/></p>
<b>Question 20a:</b>	<p>If you attended an outpatient clinic in the last year, what was the reason?</p> <div style="border: 1px solid black; height: 120px; width: 100%;"></div>
<b>Question 21:</b>	<p><b>In the last year, how many times were you admitted to hospital overnight?</b></p> <p><b>Note:</b> These are sometimes called in-patient admissions.</p> <p>Number of admissions <input type="text"/></p> <p>Don't know <input type="text"/></p>
<b>Question 22:</b>	<p><b>In the last year, how many nights did you spend in an Acute/general hospital?</b></p> <p>Number of nights <input type="text"/></p> <p>Don't know <input type="text"/></p>

<b>Question 22a:</b>	<p>If you attended a hospital overnight for treatment in the last year, what was the reason?</p> <div style="border: 1px solid black; height: 100px; width: 100%;"></div>																		
<b>Question 23:</b>	<p>Please tell us the name(s) of the hospital(s) you were in over the last year. For example (St James’s Hospital Dublin OR Louth County, Dundalk)</p> <table border="1" data-bbox="300 909 1331 1688"> <thead> <tr style="background-color: #c8e6c9;"> <th data-bbox="300 909 815 965">Name of Hospital</th> <th data-bbox="815 909 1331 965">Location of Hospital</th> </tr> </thead> <tbody> <tr> <td data-bbox="300 965 815 1021" style="color: red;">Example: St James’s Hospital</td> <td data-bbox="815 965 1331 1021" style="color: red;">Dublin</td> </tr> <tr><td> </td><td> </td></tr> </tbody> </table>	Name of Hospital	Location of Hospital	Example: St James’s Hospital	Dublin														
Name of Hospital	Location of Hospital																		
Example: St James’s Hospital	Dublin																		
<b>Question 24:</b>	<p>In the last year, how many nights did you spend in an acute/psychiatric hospital due to mental health problems?</p> <p>Number of nights <input style="width: 40px; height: 20px; border: 1px solid black;" type="text"/></p>																		

	Don't know <input type="checkbox"/>								
<b>Question 25:</b>	<p><b>In the last year, how many nights did you spend in respite?</b></p> <p>Number of nights <input type="checkbox"/></p> <p>Don't know <input type="checkbox"/></p>								
<b>Question 26:</b>	<p>This question asks for more information about your nights spent in respite in the last year.</p> <p>Didn't spend any nights in respite <input type="checkbox"/> <b>Go to Q. 27</b></p> <p>If you have spent nights in respite in the last year, please tell us how many nights you have spent in each of the following:</p> <table border="1" data-bbox="300 1115 1278 1346"> <tr> <td>In a community setting</td> <td></td> </tr> <tr> <td>In a service provider setting</td> <td></td> </tr> <tr> <td>In a nursing/convalescent home</td> <td></td> </tr> <tr> <td>Don't know</td> <td></td> </tr> </table>	In a community setting		In a service provider setting		In a nursing/convalescent home		Don't know	
In a community setting									
In a service provider setting									
In a nursing/convalescent home									
Don't know									

<p><b>Question 27:</b></p>	<p><b>In the last year how many hours per week did you use a personal care attendant on a typical week?</b></p> <p>Number of nights <input type="checkbox"/></p> <p>Don't know <input type="checkbox"/></p>						
<p><b>Question 28:</b></p>	<p><b>Are there any services that you think you would benefit from that you are not receiving at present?</b></p> <p>Please tick one box only</p> <table border="1" data-bbox="395 840 1214 1010"> <tr> <td>YES</td> <td><input type="checkbox"/></td> </tr> <tr> <td>NO</td> <td><input type="checkbox"/></td> </tr> <tr> <td>Don't Know</td> <td><input type="checkbox"/></td> </tr> </table> <p><b>If YES, please specify</b></p>	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>	Don't Know	<input type="checkbox"/>
YES	<input type="checkbox"/>						
NO	<input type="checkbox"/>						
Don't Know	<input type="checkbox"/>						

## F) Section F: How happy are you with your health services

The next few questions ask how satisfied or happy you are with the service you get from your health care providers.

<b>Question 29:</b>	<p><b>Are all staff at the health services nice and polite to you?</b></p> <p>Please tick one box on every line</p> <table border="1" style="width: 100%; border-collapse: collapse; text-align: center;"> <thead> <tr style="background-color: #c8e6c9;"> <th style="width: 25%;"></th> <th style="width: 12.5%;">Yes, all staff</th> <th style="width: 12.5%;">Yes, some staff</th> <th style="width: 12.5%;">No</th> <th style="width: 12.5%;">Don't know</th> <th style="width: 12.5%;">Does not apply</th> </tr> </thead> <tbody> <tr> <td style="text-align: left;">Doctors/GP surgery</td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr style="background-color: #c8e6c9;"> <td style="text-align: left;">Dentist's office</td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td style="text-align: left;">General hospital</td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> </tbody> </table>		Yes, all staff	Yes, some staff	No	Don't know	Does not apply	Doctors/GP surgery						Dentist's office						General hospital					
	Yes, all staff	Yes, some staff	No	Don't know	Does not apply																				
Doctors/GP surgery																									
Dentist's office																									
General hospital																									
<b>Question 30:</b>	<p><b>When you go to the health services, do you have the support (family/staff) to get there?</b></p> <p>Please tick one box on every line</p> <table border="1" style="width: 100%; border-collapse: collapse; text-align: center;"> <thead> <tr style="background-color: #c8e6c9;"> <th style="width: 16.6%;"></th> <th style="width: 16.6%;">Almost always</th> <th style="width: 16.6%;">Sometimes</th> <th style="width: 16.6%;">Almost never</th> <th style="width: 16.6%;">Don't know</th> <th style="width: 16.6%;">Does not apply</th> </tr> </thead> <tbody> <tr> <td style="text-align: left;">Doctors/GP surgery</td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr style="background-color: #c8e6c9;"> <td style="text-align: left;">Dentist's office</td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td style="text-align: left;">General hospital</td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> </tbody> </table>		Almost always	Sometimes	Almost never	Don't know	Does not apply	Doctors/GP surgery						Dentist's office						General hospital					
	Almost always	Sometimes	Almost never	Don't know	Does not apply																				
Doctors/GP surgery																									
Dentist's office																									
General hospital																									

**Question 31:** When you go to the health services, do you have the transport to get there?

Please tick one box on every line

	Almost always	Sometimes	Almost never	Don't know	Does not apply
Doctors/GP surgery					
Dentist's office					
General hospital					

**Question 32:** Can you think of anything you asked for help with but didn't get?

Please tick one box only

Yes		Go to Q. 33
No		Go to Q. 34
Don't know		Go to Q. 34

IF YES (Please specify)

**Question 33:** Please tell us the main thing that stops/prevents you from getting this service or services?

Don't know

## G) Section G: The exercise you do

### Rapid Assessment of Physical Activity

Physical Activities are activities where you move and increase your heart rate above its resting rate, whether you do them for pleasure, work, or transportation.

The following questions ask about the amount and intensity of physical activity you usually do. The intensity of the activity is related to the amount of energy you use to do these activities.

<p><b>Light activities</b></p> <p>your heart beats slightly faster than normal</p> <p>you can talk and sing</p>	<div style="display: flex; justify-content: space-around; align-items: center;"> <div style="text-align: center;">  <p>Walking Leisurely</p> </div> <div style="text-align: center;">  <p>Stretching</p> </div> <div style="text-align: center;">  <p>Vacuuming or Light Yard work</p> </div> </div>
<p><b>Moderate activities</b></p> <ul style="list-style-type: none"> <li>• your heart beats faster than normal</li> <li>• you can talk but not sing</li> </ul>	<div style="display: flex; justify-content: space-around; align-items: center;"> <div style="text-align: center;">  <p>Fast Walking</p> </div> <div style="text-align: center;">  <p>Aerobics Class</p> </div> <div style="text-align: center;">  <p>Strength Training</p> </div> <div style="text-align: center;">  <p>Swimming Gently</p> </div> </div>
<p><b>Vigorous activities</b></p> <ul style="list-style-type: none"> <li>• your heart rate increases a lot</li> <li>• you can't talk or your talking is broken up by large breaths</li> </ul>	<div style="display: flex; justify-content: space-around; align-items: center;"> <div style="text-align: center;">  <p>Stair Machin</p> </div> <div style="text-align: center;">  <p>Jogging or running</p> </div> <div style="text-align: center;">  <p>Tennis, Racquetball, Pickleball or Badminton</p> </div> </div>

**Question 34:****How physically active are you?****(Please circle or tick the answer that applies to you on each line)**

I rarely or never do any physical activities	YES	NO
I do some <b>light</b> or <b>moderate</b> physical activities, but not every week	YES	NO
I do some light physical activity every week	YES	NO
I do moderate physical activities every week, but less than 30 minutes a day or 5 days a week	YES	NO
I do vigorous physical activities every week, but less than 20 minutes a day or 3 days a week	YES	NO
I do 30 minutes or more a day of moderate physical activities, 5 or more days a week	YES	NO
I do 20 minutes or more a day of vigorous physical activities, 3 or more days a week	YES	NO
I do activities to increase muscle strength, such as lifting weights or calisthenics, once a week or more	YES	NO
I do activities to improve flexibility, such as stretching or yoga, once a week or more	YES	NO

Please get your Carer/Key worker/Support person to complete this section

## H) Section H: Behaviours that Challenge

**Question 35:** Below you will find broad definitions followed by specific items for three types of behaviour problems:

1. Self-injurious behaviours (items 1-8),
2. Aggressive/destructive behaviours (items 9-18), and
3. Stereotyped behaviours (items 19-30).

Indicate which behaviours you have observed in this individual during the past two months by circling the number in the appropriate boxes (1) how often a described behaviour typically occurs and (2) how serious a problem the behaviour is. If the behaviour has not occurred during the past two months and therefore poses no problem, check "never/no problem" ("0"). If the behaviour has occurred, rate the approximate frequency of its occurrence and its severity (use the definitions below; note, no severity scale is provided for stereotyped behaviour.)

### SELF-INJURIOUS BEHAVIOUR

Mild Problem	Moderate Problem	Severe Problem
Behaviour occurs but does not inflict significant damage on the individual (e.g., temporary reddening of the skin, very light bruising).	Behaviour may inflict moderate damage on the individual (e.g., moderate bruising, scratching through the skin, repeatedly picking scabs.	Behaviour may inflict moderate to severe damage on the individual (e.g. biting through the skin, eye gouging, fracturing bones) minor or major medical intervention required.

	Self-injurious behavior (SIB) causes damage to the person's own body; i.e., damage has either already occurred, or it must be expected if the behavior remained untreated. SIBs occur repeatedly in the same way over and over again, and they are characteristic for that person.	Never / no problem	Average Frequency of Occurrence				Severity of the Problem		
			Monthly	Weekly	Daily	Hourly	Mild	Moderate	Severe
1.	Self-biting	0	1	2	3	4	1	2	3
2.	Head hitting	0	1	2	3	4	1	2	3
3.	Body hitting (except for the head) with own hand or with any other body part	0	1	2	3	4	1	2	3
4.	Self-scratching	0	1	2	3	4	1	2	3

5.	<b>Pica (ingesting non-food items)</b>	0	1	2	3	4	1	2	3
6.	<b>Inserting objects in nose, ears, anus, etc.</b>	0	1	2	3	4	1	2	3
7.	<b>Hair pulling (tearing out patches of hair)</b>	0	1	2	3	4	1	2	3
8.	<b>Teeth grinding (evidence of ground teeth)</b>	0	1	2	3	4	1	2	3

**Is there a psychological or non-pharmacological intervention in place to address this behavior?**

Please tick one box only

Yes	<input checked="" type="checkbox"/>
No	<input type="checkbox"/>
Not applicable	<input checked="" type="checkbox"/>
Don't know	<input type="checkbox"/>

If 'Yes' please describe this intervention

**AGGRESSIVE/DESTRUCTIVE BEHAVIOUR**

Mild Problem	Moderate Problem	Severe Problem
Behaviour occurs but does not inflict significant damage on other people (e.g., temporary reddening of the skin, very light bruising); or disruption or mild damage to property, e.g., objects thrown, furniture tipped, doors	The behaviour may inflict moderate damage on other people (e.g., moderate bruising, scratching through the skin, repeatedly picking scabs; or moderate damage to property (e.g., curtains torn, furniture partly broken). Item requires repair but can be used.	The behaviour may inflict moderate to severe damage on other people (e.g. biting through the skin, eye gouging, fracturing bones) minor or major medical intervention required; or significant damage to property. Item requires repair and cannot be used.

Aggressive or destructive behaviors are deliberate overt attacks directed towards other individuals or property.		Never / no problem	Average Frequency of Occurrence				Severity of the Problem		
			Monthly	Weekly	Daily	Hourly	Mild	Moderate	Severe
9.	Hitting others	0	1	2	3	4	1	2	3
10.	Kicking others	0	1	2	3	4	1	2	3
11.	Pushing others	0	1	2	3	4	1	2	3
12.	Biting others	0	1	2	3	4	1	2	3
13.	Grabbing and pulling others	0	1	2	3	4	1	2	3
14.	Scratching others	0	1	2	3	4	1	2	3
15.	Pinching others	0	1	2	3	4	1	2	3
16.	Verbally abusive with others	0	1	2	3	4	1	2	3

17.	<b>Destroying things (e.g., rips clothes, throws chairs, smashes tables)</b>	0	1	2	3	4	1	2	3
18.	<b>Bullying - being mean or cruel (e.g., grabbing toys or food from others)</b>	0	1	2	3	4	1	2	3

**Is there a psychological or non-pharmacological intervention in place to address this behavior?**

Please tick one box only

Yes	<input type="checkbox"/>
No	<input type="checkbox"/>
Not applicable	<input type="checkbox"/>
Don't know	<input type="checkbox"/>

If 'Yes' please describe this intervention

### STEREOTYPED BEHAVIOUR

Stereotyped behaviors look unusual, strange, or inappropriate to the average person. They are voluntary acts that occur repeatedly in the same way over and over again, and they are characteristic for that person. However, they do NOT cause physical damage.		Average Frequency of Occurrence				
		Never /no problem	Monthly	Weekly	Daily	Hourly
19.	<b>Rocking, repetitive body movements</b>	0	1	2	3	4
20.	<b>Sniffing objects, own body</b>	0	1	2	3	4
21.	<b>Waving or shaking arms</b>	0	1	2	3	4
22.	<b>Manipulating (e.g., twirling, spinning) objects</b>	0	1	2	3	4
23.	<b>Repetitive hand and/or finger movements</b>	0	1	2	3	4
24.	<b>Yelling and screaming</b>	0	1	2	3	4
25.	<b>Pacing, jumping, bouncing, running</b>	0	1	2	3	4

26.	<b>Rubbing self</b>	0	1	2	3	4
27.	<b>Gazing at hands or objects</b>	0	1	2	3	4
28.	<b>Bizarre body postures</b>	0	1	2	3	4
29.	<b>Clapping hands</b>	0	1	2	3	4
30.	<b>Grimacing</b>	0	1	2	3	4

**Is there a psychological or non-pharmacological intervention in place to address this behavior?**

Please tick one box only

Yes	<input type="checkbox"/>
No	<input type="checkbox"/>
Not applicable	<input type="checkbox"/>
Don't know	<input type="checkbox"/>

If 'Yes' please describe this intervention

## I) Section I: Medications

**Question 36: We would like to record all medications that you take on a regular basis, every day or every week. This will include prescription and non-prescription medications, over-the-counter medicines, vitamins and herbal and alternative medicines.**

Don't take any medication

**Go to Question 37**

**PLEASE WRITE DOWN DETAILS OF ALL MEDICATIONS/TABLETS. USE ONE LINE PER MEDICATION AND FOLLOW THE EXAMPLE GIVEN BELOW**

Name of Medication	Dosage Strength	Frequency	Route	Date first Prescribed
Epilim Chrono tablets	200mgs	Twice a day (BD)	Orally (PO)	Sept 2009
One touch ultra test strip(blood glucose)	1 strip	Before meals	-	June 2015
Neo-cytamen Injection(hydroxycobalamin)	1000mgs	Monthly	IM	Nov 2010
Xalatan eye drops	2 drops (left eye)	Nocte (At night)	Instill	June 2010
Emulsifying Ointment		PRN	Topically	Jan 2009
Evening Primrose Oil capsules	1000mg	1 daily	PO	June 2005
Ensure Plus Drinks		1 daily	PO	Oct 2021

Please tick if the medicines listed below have been verified from Kardex /case record

	Name of Medication	Dosage Strength	Frequency	Route	Date first Prescribed
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					
11.					
12.					
13.					

14.					
15.					
16.					
17.					
18.					
19.					
20.					
21.					
22.					
23.					
24.					
25.					
26.					
27.					
28.					
29.					
30.					

**Question 37:**

Some studies like TILDA link the information they collect with official health records to provide a complete picture about the health and treatment history of the participant.

Please note we are interested in linking with official health records from this Wave 5 study period.

Would you be happy to provide us with your medical card number/ Drugs Payment Scheme (DPS)/Long Term Illness (LTI) number for this purpose?  
Please note: Some people may have both a medical card number **OR** Drugs Payment Scheme number **AND** a Long Term Illness number.

Please tick one box only

Yes	<input type="checkbox"/>	
No	<input type="checkbox"/>	<b>Go to Q. 38</b>
Don't know	<input type="checkbox"/>	<b>Go to Q. 38</b>

If yes, please write your medical card number/Drugs Payment Scheme number in the box below.

If you have an LTI number, please provide your LTI number in the box below.

*Your LTI number will be on the inside front cover of your green LTI book (circled below). You can also get this number from your pharmacy.*

**SECTION A** (For completion by Health Board)

Name of Holder: BLOGGS, JOSEPH

Address: 123 Main St  
Ballysmalltown

Patient No. 12345

Signature of authorizing officer: John Doe

Health Board stamp, address and telephone no.:

**Question 38:**

**Have you ever received any easy to read information leaflets about your medication?**

Please tick one box only

Yes		<b>Go to Q. 39</b>
No		<b>Go to Q. 40</b>
Don't know		<b>Go to Q. 40</b>

**Question 39:**

**If you have received information leaflets about your medication, please tell us who gave you these leaflets from the list below.**

PLEASE TICK ALL THAT APPLY

General Practitioner	<input type="checkbox"/>
Pharmacist	<input type="checkbox"/>
Public Health Nurse	<input type="checkbox"/>
RNID (Registered Nurse in Intellectual Disability)	<input type="checkbox"/>
Don't know	<input type="checkbox"/>
Other	<input type="checkbox"/>

Other (please tell us)

## J) Section J: Sources of Income

**Question 40:** This section asks questions about the money you get and how much money you have to spend on things you like to do.

Didn't receive any payments in the last year  **Go to Q. 41**

Don't know if received payments in the last year  **Go to Q. 41**

**If you did, please tick all the types of payments that you have received in the last year.**

Income from current employment	
Disability allowance	
Mobility allowance	
Disability benefit (previously known as illness benefit)	
Retirement pension from former employment	
Contributory state pension (previously known as Non-Contributory old age pension)	
Transition state pension (previously known as retirement pension)	
Invalidity pension	
Widow's or Widower's contributory pension	
Private pension	
Jobseeker's allowance (previously known as unemployment assistance)	
Jobseeker's benefit (previously known as unemployment benefit)	
Supplementary welfare allowance	
Don't know	
Other (please specify)	

<p><b>Question 41:</b></p>	<p><b>Once you have paid all of your bills, how much money do you have every week?</b></p> <p>€ _____ Total amount</p> <p>(From CAPI SI_30.3 new q)</p>									
<p><b>Question 42:</b></p>	<p><b>Have you ever had an assessment of financial capacity undertaken with you?</b></p> <p>Financial capacity is when someone asks you questions about how you manage your money and how you make decisions about spending or saving your money to check if you would need some support with making these decisions?</p> <p>These may be decisions about how to spend your money on everyday items like buying food and drink, as well as decisions about buying bigger things such as television, a care, a house</p> <p>Please tick one box only</p> <table border="1" data-bbox="376 1238 876 1408"> <tr> <td>Yes</td> <td><input type="checkbox"/></td> </tr> <tr> <td>No</td> <td><input type="checkbox"/></td> </tr> <tr> <td>Don't know</td> <td><input type="checkbox"/></td> </tr> </table>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Don't know	<input type="checkbox"/>			
Yes	<input type="checkbox"/>									
No	<input type="checkbox"/>									
Don't know	<input type="checkbox"/>									
<p><b>Question 43:</b></p>	<p><b>Do you have your own bank account?</b></p> <p>Please tick one box only</p> <table border="1" data-bbox="376 1621 1200 1792"> <tr> <td>Yes</td> <td><input type="checkbox"/></td> <td><b>Go to Q. 44</b></td> </tr> <tr> <td>No</td> <td><input type="checkbox"/></td> <td><b>Go to Q. 45</b></td> </tr> <tr> <td>Don't know</td> <td><input type="checkbox"/></td> <td><b>Go to Q. 45</b></td> </tr> </table>	Yes	<input type="checkbox"/>	<b>Go to Q. 44</b>	No	<input type="checkbox"/>	<b>Go to Q. 45</b>	Don't know	<input type="checkbox"/>	<b>Go to Q. 45</b>
Yes	<input type="checkbox"/>	<b>Go to Q. 44</b>								
No	<input type="checkbox"/>	<b>Go to Q. 45</b>								
Don't know	<input type="checkbox"/>	<b>Go to Q. 45</b>								

**Question 44:** If you have a card with your bank account, who has access to your bank card?

Tick all that apply

Myself	<input checked="" type="checkbox"/>
Family	<input type="checkbox"/>
Keyworker	<input checked="" type="checkbox"/>
Service provider	<input type="checkbox"/>
Friend(s)	<input checked="" type="checkbox"/>

## K) Section K: Transport

**Question 45:**

**Within the last year, have you used any of the following means of transport?**

Didn't use any transport in the last year

**Go to Q. 51**

Don't know if any transport used in the last year

**Go to Q. 51**

If you did, tick all that apply

Bicycle/motorbike	
Drive myself	
Driven as a passenger by family	
Driven as a passenger by friends	
Driven as a passenger by service staff	
Public bus (city or urban)	
Public bus (intercity)	
Public buses (rural)	
Taxi/hackney	
DART/Luas	
Train (commuter)	
Bus operating as part of the rural transport scheme	
Don't know	
Other (please specify)	

(Adapted from ELSA/TILDA)

**Question 46:**

**Which of these methods of transport do you use most often?**

Please tick one box only

Bicycle/motorbike	<input type="checkbox"/>
Drive myself	<input type="checkbox"/>
Driven as a passenger by family	<input type="checkbox"/>
Driven as a passenger by friends	<input type="checkbox"/>
Driven as a passenger by service staff	<input type="checkbox"/>
Public bus (city or urban)	<input type="checkbox"/>
Public bus (intercity)	<input type="checkbox"/>
Public buses (rural)	<input type="checkbox"/>
Taxi/hackney	<input type="checkbox"/>
DART/Luas	<input type="checkbox"/>
Train (commuter)	<input type="checkbox"/>
Bus operating as part of the rural transport scheme	<input type="checkbox"/>
Don't know	<input type="checkbox"/>
Other (please specify)	<input type="checkbox"/>

(TILDA)

<p><b>Question 47:</b></p>	<p><b>Do you feel there is a lack of transport facilities in your area?</b></p> <p>Please tick one box only</p> <table border="1"> <tr> <td>Yes</td> <td><input type="checkbox"/></td> <td>Go to Q. 48</td> </tr> <tr> <td>No</td> <td><input type="checkbox"/></td> <td>Go to Q. 49</td> </tr> <tr> <td>Don't know</td> <td><input type="checkbox"/></td> <td>Go to Q. 49</td> </tr> </table>	Yes	<input type="checkbox"/>	Go to Q. 48	No	<input type="checkbox"/>	Go to Q. 49	Don't know	<input type="checkbox"/>	Go to Q. 49
Yes	<input type="checkbox"/>	Go to Q. 48								
No	<input type="checkbox"/>	Go to Q. 49								
Don't know	<input type="checkbox"/>	Go to Q. 49								
<p><b>Question 48:</b></p>	<p><b>Does the lack of transport facilities in your area affect your lifestyle?</b></p> <p>Please tick one box only</p> <table border="1"> <tr> <td>A great deal</td> <td><input type="checkbox"/></td> </tr> <tr> <td>To some extent</td> <td><input type="checkbox"/></td> </tr> <tr> <td>Not at all</td> <td><input type="checkbox"/></td> </tr> <tr> <td>Don't know</td> <td><input type="checkbox"/></td> </tr> </table>	A great deal	<input type="checkbox"/>	To some extent	<input type="checkbox"/>	Not at all	<input type="checkbox"/>	Don't know	<input type="checkbox"/>	
A great deal	<input type="checkbox"/>									
To some extent	<input type="checkbox"/>									
Not at all	<input type="checkbox"/>									
Don't know	<input type="checkbox"/>									
<p><b>Question 49:</b></p>	<p><b>What would you consider are the most important improvements that could be made to the transport options available to you?</b></p> <div style="border: 1px solid black; height: 150px; width: 100%;"></div>									
<p><b>Question 50:</b></p>	<p><b>Any other Information (Transport)</b></p> <div style="border: 1px solid black; height: 80px; width: 100%;"></div>									

## L) Section L: Living Circumstances

**Question 51: Do you have a key to your own home?**

Please tick one box only

Yes	
No	
Don't know	

(McConkey et al. 2016)

**Question 52: How many people live under the same roof as you?**

By live we mean people who are NOT paid staff and who reside at this residence for the majority of the week (e.g. family members, other people with ID).

Number of People	
------------------	--

Don't know	
------------	--

(Adapted POMONA)

**Question 53: Do you have your own bedroom for yourself?**

Please tick one box only

Yes		<b>Go to Q. 56</b>
No		<b>Go to Q. 54</b>
Don't know		<b>Go to Q. 56</b>

<p><b>Question 54:</b></p>	<p><b>How many people do you share a bedroom with? (other than with a partner)</b></p> <table border="1" data-bbox="368 304 1166 416"> <tr> <td data-bbox="368 304 804 416">Number of People</td> <td data-bbox="804 304 1166 416"></td> </tr> </table> <table border="1" data-bbox="368 472 751 528"> <tr> <td data-bbox="368 472 676 528">Don't know</td> <td data-bbox="676 472 751 528"></td> </tr> </table> <p>(National Quality standards HIQA/IDS-TILDA)</p>	Number of People		Don't know										
Number of People														
Don't know														
<p><b>Question 55:</b></p>	<p><b>Would you prefer to have your own bedroom?</b></p> <p>Please tick one box only</p> <table border="1" data-bbox="368 719 954 965"> <tr> <td data-bbox="368 719 868 779">Yes</td> <td data-bbox="868 719 954 779"><input checked="" type="checkbox"/></td> </tr> <tr> <td data-bbox="368 779 868 840">No</td> <td data-bbox="868 779 954 840"><input type="checkbox"/></td> </tr> <tr> <td data-bbox="368 840 868 900">Not applicable</td> <td data-bbox="868 840 954 900"><input checked="" type="checkbox"/></td> </tr> <tr> <td data-bbox="368 900 868 965">Don't know</td> <td data-bbox="868 900 954 965"><input type="checkbox"/></td> </tr> </table> <p>(National Quality Standards HIQA/IDS-TILDA)</p>	Yes	<input checked="" type="checkbox"/>	No	<input type="checkbox"/>	Not applicable	<input checked="" type="checkbox"/>	Don't know	<input type="checkbox"/>					
Yes	<input checked="" type="checkbox"/>													
No	<input type="checkbox"/>													
Not applicable	<input checked="" type="checkbox"/>													
Don't know	<input type="checkbox"/>													
<p><b>Question 56:</b></p>	<p><b>Do you receive support from nursing staff in your residence?</b></p> <p>Please tick one box only</p> <table border="1" data-bbox="368 1171 933 1697"> <tr> <td data-bbox="368 1171 820 1232">24 Hours a day</td> <td data-bbox="820 1171 933 1232"><input checked="" type="checkbox"/></td> </tr> <tr> <td data-bbox="368 1232 820 1292">Only at night</td> <td data-bbox="820 1232 933 1292"><input type="checkbox"/></td> </tr> <tr> <td data-bbox="368 1292 820 1352">Only during the day</td> <td data-bbox="820 1292 933 1352"><input checked="" type="checkbox"/></td> </tr> <tr> <td data-bbox="368 1352 820 1464">Part time both at day and night</td> <td data-bbox="820 1352 933 1464"><input type="checkbox"/></td> </tr> <tr> <td data-bbox="368 1464 820 1632">Not applicable (no paid nursing staff in your house day or night)</td> <td data-bbox="820 1464 933 1632"><input checked="" type="checkbox"/></td> </tr> <tr> <td data-bbox="368 1632 820 1697">Don't know</td> <td data-bbox="820 1632 933 1697"><input type="checkbox"/></td> </tr> </table> <p>Other, (Please specify)</p> <table border="1" data-bbox="368 1809 1353 1973"> <tr> <td data-bbox="368 1809 1353 1973"></td> </tr> </table> <p>(Adapted from POMONA)</p>	24 Hours a day	<input checked="" type="checkbox"/>	Only at night	<input type="checkbox"/>	Only during the day	<input checked="" type="checkbox"/>	Part time both at day and night	<input type="checkbox"/>	Not applicable (no paid nursing staff in your house day or night)	<input checked="" type="checkbox"/>	Don't know	<input type="checkbox"/>	
24 Hours a day	<input checked="" type="checkbox"/>													
Only at night	<input type="checkbox"/>													
Only during the day	<input checked="" type="checkbox"/>													
Part time both at day and night	<input type="checkbox"/>													
Not applicable (no paid nursing staff in your house day or night)	<input checked="" type="checkbox"/>													
Don't know	<input type="checkbox"/>													

**Question 57:** Do you receive support from other staff (e.g. key worker, support worker) in your residence (excluding nursing staff)?

Please tick one box only

24 Hours a day	<input type="checkbox"/>
Only at night	<input type="checkbox"/>
Only during the day	<input type="checkbox"/>
Part time both at day and night	<input type="checkbox"/>
Not applicable (no paid nursing staff in your/his/her] house day or night)	<input type="checkbox"/>
Don't know	<input type="checkbox"/>

Other, please specify

(Adapted from POMONA)

**Question 58:** Thinking about your current home do you ...?

Please tick one box only

Own this residence/have mortgage	<input type="checkbox"/>	Go to Q. 60
Family own the residence	<input type="checkbox"/>	Go to Q. 60
Rent – From service provider	<input type="checkbox"/>	Go to Q. 59
Rent – From private landlord	<input type="checkbox"/>	Go to Q. 59
Rent – From local authority / social housing	<input type="checkbox"/>	Go to Q. 59
Does not pay rent / Not applicable	<input type="checkbox"/>	Go to Q. 60
Don't know	<input type="checkbox"/>	Go to Q. 60
Rent - Other (Please specify)	<input type="checkbox"/>	Go to Q. 59

<p><b>Question 59:</b></p>	<p><b>Do you have a tenancy agreement between you and the person you rent from?</b></p> <p>Please tick one box only</p> <table border="1"> <tr> <td>Yes</td> <td><input checked="" type="checkbox"/></td> </tr> <tr> <td>No</td> <td><input type="checkbox"/></td> </tr> <tr> <td>Don't know</td> <td><input checked="" type="checkbox"/></td> </tr> </table>	Yes	<input checked="" type="checkbox"/>	No	<input type="checkbox"/>	Don't know	<input checked="" type="checkbox"/>						
Yes	<input checked="" type="checkbox"/>												
No	<input type="checkbox"/>												
Don't know	<input checked="" type="checkbox"/>												
<p><b>Question 60:</b></p>	<p><b>Is your residence...?</b></p> <p>Please tick one box only</p> <table border="1"> <tr> <td>A bungalow or 1 storey house</td> <td><input checked="" type="checkbox"/></td> </tr> <tr> <td>A house with 2 or more stories</td> <td><input type="checkbox"/></td> </tr> <tr> <td>A ground floor flat</td> <td><input checked="" type="checkbox"/></td> </tr> <tr> <td>A flat/apartment/maisonette on upper storey, with lift</td> <td><input type="checkbox"/></td> </tr> <tr> <td>A flat/apartment/maisonette on upper storey, with no lift</td> <td><input checked="" type="checkbox"/></td> </tr> <tr> <td>Don't know</td> <td><input type="checkbox"/></td> </tr> </table> <p>Other (Please specify)</p> <div style="border: 1px solid black; height: 60px; width: 100%;"></div> <p>(NDS/IDS-TILDA)</p>	A bungalow or 1 storey house	<input checked="" type="checkbox"/>	A house with 2 or more stories	<input type="checkbox"/>	A ground floor flat	<input checked="" type="checkbox"/>	A flat/apartment/maisonette on upper storey, with lift	<input type="checkbox"/>	A flat/apartment/maisonette on upper storey, with no lift	<input checked="" type="checkbox"/>	Don't know	<input type="checkbox"/>
A bungalow or 1 storey house	<input checked="" type="checkbox"/>												
A house with 2 or more stories	<input type="checkbox"/>												
A ground floor flat	<input checked="" type="checkbox"/>												
A flat/apartment/maisonette on upper storey, with lift	<input type="checkbox"/>												
A flat/apartment/maisonette on upper storey, with no lift	<input checked="" type="checkbox"/>												
Don't know	<input type="checkbox"/>												
<p><b>Question 61:</b></p>	<p><b>Is your residence adapted or not adapted to meet your needs?</b></p> <p>Please tick one box only</p> <table border="1"> <tr> <td>Adapted</td> <td><input checked="" type="checkbox"/></td> </tr> <tr> <td>Not adapted</td> <td><input type="checkbox"/></td> </tr> <tr> <td>Don't know</td> <td><input checked="" type="checkbox"/></td> </tr> </table>	Adapted	<input checked="" type="checkbox"/>	Not adapted	<input type="checkbox"/>	Don't know	<input checked="" type="checkbox"/>						
Adapted	<input checked="" type="checkbox"/>												
Not adapted	<input type="checkbox"/>												
Don't know	<input checked="" type="checkbox"/>												

<p><b>Question 62:</b></p>	<p><b>Does your residence have a bathroom, bedroom and kitchen all on the same floor or level?</b></p> <p>Please tick one box only</p> <table border="1"> <tr> <td>Yes</td> <td><input type="checkbox"/></td> </tr> <tr> <td>No</td> <td><input type="checkbox"/></td> </tr> <tr> <td>Not applicable</td> <td><input type="checkbox"/></td> </tr> <tr> <td>Don't know</td> <td><input type="checkbox"/></td> </tr> </table> <p>(Adapted from Disability Follow back Survey)</p>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Not applicable	<input type="checkbox"/>	Don't know	<input type="checkbox"/>				
Yes	<input type="checkbox"/>												
No	<input type="checkbox"/>												
Not applicable	<input type="checkbox"/>												
Don't know	<input type="checkbox"/>												
<p><b>Question 63:</b></p>	<p><b>Do you have any difficulty getting around inside your home for example, getting to and from the toilet, going from room to room, such as your bedroom to the living room?</b></p> <p>Please tick one box only</p> <table border="1"> <tr> <td>No difficulty</td> <td><input type="checkbox"/></td> </tr> <tr> <td>Some difficulty</td> <td><input type="checkbox"/></td> </tr> <tr> <td>A lot of difficulty</td> <td><input type="checkbox"/></td> </tr> <tr> <td>Cannot do at all</td> <td><input type="checkbox"/></td> </tr> </table> <p>(Adapted from NDS)</p>	No difficulty	<input type="checkbox"/>	Some difficulty	<input type="checkbox"/>	A lot of difficulty	<input type="checkbox"/>	Cannot do at all	<input type="checkbox"/>				
No difficulty	<input type="checkbox"/>												
Some difficulty	<input type="checkbox"/>												
A lot of difficulty	<input type="checkbox"/>												
Cannot do at all	<input type="checkbox"/>												
<p><b>Question 64:</b></p>	<p><b>Have any modifications been made to your home to help you get around?</b></p> <p>Please tick one box only</p> <table border="1"> <tr> <td>Yes</td> <td><input type="checkbox"/></td> <td><b>Go to Q. 65</b></td> </tr> <tr> <td>No – but modifications are needed</td> <td><input type="checkbox"/></td> <td><b>Go to Q. 65</b></td> </tr> <tr> <td>No – and modifications are not needed</td> <td><input type="checkbox"/></td> <td><b>Go to Q. 68</b></td> </tr> <tr> <td>Don't know</td> <td><input type="checkbox"/></td> <td><b>Go to Q. 65</b></td> </tr> </table> <p>(IDS-TILDA)</p>	Yes	<input type="checkbox"/>	<b>Go to Q. 65</b>	No – but modifications are needed	<input type="checkbox"/>	<b>Go to Q. 65</b>	No – and modifications are not needed	<input type="checkbox"/>	<b>Go to Q. 68</b>	Don't know	<input type="checkbox"/>	<b>Go to Q. 65</b>
Yes	<input type="checkbox"/>	<b>Go to Q. 65</b>											
No – but modifications are needed	<input type="checkbox"/>	<b>Go to Q. 65</b>											
No – and modifications are not needed	<input type="checkbox"/>	<b>Go to Q. 68</b>											
Don't know	<input type="checkbox"/>	<b>Go to Q. 65</b>											

**Question 65: What modifications have been (need to be) made?**

Please tick all that apply

	Have been made	Need to be made
Ramps on street level entrances		
Automatic or easy to open doors (includes lever handles)		
Widened doorways or hallways		
Lift device		
Visual alarms or audio warning devices		
Grab bars or a bath lift (in the bathroom)		
Lowered counters in the kitchen		
Don't know		
Other (please specify)		

(NDS Adapted by IDS-TILDA)

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**Question 66: What was the total cost of modifications made to [your/his/her] home?**

Please write the amount to the nearest €100

€ \_\_\_\_\_

Don't know	
------------	--

(TILDA)

**If you paid for any of the home modifications yourself, how much did you pay?**

Please write the amount to the nearest €100

€ \_\_\_\_\_

Don't know	
------------	--

(TILDA)

<p><b>Question 67:</b></p>	<p><b>Were any of the costs of the modifications covered by the State?</b></p> <p>Please tick one box only</p> <table border="1" data-bbox="368 353 1120 584"> <tr> <td data-bbox="368 353 852 412">Yes, all of the costs</td> <td data-bbox="852 353 987 412"></td> <td data-bbox="987 353 1120 412"></td> </tr> <tr> <td data-bbox="368 412 852 470">Yes, some of the costs</td> <td data-bbox="852 412 987 470"></td> <td data-bbox="987 412 1120 470"></td> </tr> <tr> <td data-bbox="368 470 852 528">No, none of the costs</td> <td data-bbox="852 470 987 528"></td> <td data-bbox="987 470 1120 528"></td> </tr> <tr> <td data-bbox="368 528 852 584">Don't know</td> <td data-bbox="852 528 987 584"></td> <td data-bbox="987 528 1120 584"></td> </tr> </table> <p>(TILDA)</p>	Yes, all of the costs			Yes, some of the costs			No, none of the costs			Don't know		
Yes, all of the costs													
Yes, some of the costs													
No, none of the costs													
Don't know													
<p><b>Question 68:</b></p>	<p><b>Any other information (Living Circumstances)</b></p> <div data-bbox="368 696 1305 976" style="border: 1px solid black; height: 125px; width: 587px;"></div>												

## M) Section M: I (ADL) & Helpers

### Activities of daily living

**Question 69:** Please indicate the level of difficulty, if any, you have with each of the following activities –

**FOR EACH ACTIVITY TICK ONE BOX THAT APPLIES**

Level of difficulty	No difficulty	Some difficulty	A lot of difficulty	Cannot do at all
Dressing				
Walking across room				
Bathing/showering				
Eating				
Bed – in and out				
Using toilet				

**Question 70:** Does anyone ever help you with each of the following –

**FOR EACH ACTIVITY TICK ONE BOX THAT APPLIES**

Help	Yes	No	Not applicable
Dressing			
Walking across room			
Bathing/showering			
Eating			
Bed – in and out			
Using toilet			

**Question 71:**

**This question asks for more information about help you may receive from other people with any of these activities.**

Not applicable/No help needed

**Go to Q. 73**

**If you do receive help, who supports you with this activity/these activities?**

Please tick all that apply

Spouse/Partner/Boyfriend/Girlfriend	<input type="checkbox"/>
Parent	<input type="checkbox"/>
Sibling	<input type="checkbox"/>
Grandparent	<input type="checkbox"/>
Aunt / Uncle	<input type="checkbox"/>
Cousin	<input type="checkbox"/>
Key worker / Support worker	<input type="checkbox"/>
Friend	<input type="checkbox"/>
Neighbour	<input type="checkbox"/>
Home help	<input type="checkbox"/>
Public health nurse	<input type="checkbox"/>
Nurse	<input type="checkbox"/>
Health care worker	<input type="checkbox"/>

**Question 72:**

**How much help do you receive from this person (in hours and minutes per week) in a typical week?**

Please record to the nearest 15-minute interval for each person who helps you (continue to the next page)

	Hrs	Mins
Spouse/Partner/Boyfriend/Girlfriend	<input type="text"/>	<input type="text"/>
Parent	<input type="text"/>	<input type="text"/>
Sibling	<input type="text"/>	<input type="text"/>
Grandparent	<input type="text"/>	<input type="text"/>

Aunt / Uncle		
Cousin		
Key worker / Support worker		
Friend		
Neighbour		
Home help		
Public health nurse		
Nurse		
Health care worker		
Don't know		
Other (Please specify)		

**Question 73:**

**This question asks about any equipment or devices you might use to help you with dressing.**

Don't use any equipment/devices  **Go to Q. 74**

If you do, please tick all the equipment/devices that you use to help you with dressing

Velcro fastenings on clothes	
Shoehorn	
Pick-up stick	
Device for putting on socks	
Other (please specify)	

**Question 74:**

**This question asks about any equipment or devices you might use to help you with walking across a room.**

Don't use any equipment/devices

**Go to Q. 75**

**If you do, please tick all the equipment/devices that you use to help you with walking across a room**

Walking stick	<input type="checkbox"/>
Walking frame	<input type="checkbox"/>
Crutches	<input type="checkbox"/>
Railing	<input type="checkbox"/>
Orthopaedic shoes	<input type="checkbox"/>
Brace (leg or neck)	<input type="checkbox"/>
Limb prosthesis	<input type="checkbox"/>
Oxygen / Respirator	<input type="checkbox"/>
Furniture or walls	<input type="checkbox"/>
Wheelchair	<input type="checkbox"/>
Other (please specify)	<input type="checkbox"/>

**Question 75:**

**This question asks about any equipment or devices you might use to help you with bathing/showering**

Don't use any equipment/devices

**Go to Q. 76**

If you do, please tick all the equipment/devices that you use with bathing/showering

Shower seat	
Grab rails	
Hand-held shower	
Walking frame or stick	
Rubber mat	
Hoist	
Other (please specify)	

**Question 76:**

**This question asks about any equipment or devices you might use to help you with eating and drinking.**

Don't use any equipment/devices

**Go to Q. 77**

If you do, please tick all the equipment/devices that you use to help you with eating and drinking

Beakers	
Grip mats	
Modified utensils e.g. spoons, forks	
Plate guards	
Other (please specify)	

**Question 77:**

**This question asks about any equipment or devices you might use to help you with getting in and out of bed.**

Don't use any equipment/devices

**Go to Q. 78**

If you do, please tick all the equipment/devices that you use to help you with getting in and out of bed

Walking stick	<input checked="" type="checkbox"/>
Walking frame	<input type="checkbox"/>
Bed rail	<input checked="" type="checkbox"/>
Crutches	<input type="checkbox"/>
Orthopaedic Shoes	<input checked="" type="checkbox"/>
Brace (leg or back)	<input type="checkbox"/>
Prosthesis	<input checked="" type="checkbox"/>
Oxygen Respirator	<input type="checkbox"/>
Furniture / walls	<input checked="" type="checkbox"/>
Wheelchair	<input type="checkbox"/>
Bed level	<input checked="" type="checkbox"/>
Hoist	<input type="checkbox"/>
Other (please specify)	<input checked="" type="checkbox"/>

<p><b>Question 78:</b></p>	<p><b>This question asks about any equipment or devices you might use to help you with using the toilet.</b></p> <p>Don't use any equipment/devices <input type="checkbox"/> <b>Go to Q. 79</b></p> <p>If you do, please tick all the equipment/devices that you use to help you with using the toilet</p> <table border="1" data-bbox="411 633 1233 1025"> <tr> <td>Raised toilet seat</td> <td></td> </tr> <tr> <td>Portable toilet / commode</td> <td></td> </tr> <tr> <td>Grab rails</td> <td></td> </tr> <tr> <td>Other (please specify)</td> <td></td> </tr> </table>	Raised toilet seat		Portable toilet / commode		Grab rails		Other (please specify)	
Raised toilet seat									
Portable toilet / commode									
Grab rails									
Other (please specify)									
<p><b>Question 79:</b></p>	<p><b>Any Other Information (Activities of Daily Living):</b></p> <div data-bbox="411 1081 1350 1400" style="border: 1px solid black; height: 142px;"></div>								

**Instrumental Activities of daily living**

**Question 80:** Please indicate the level of difficulty, if any, you have with each of the following activities –

**FOR EACH ACTIVITY TICK ONE BOX THAT APPLIES**

Level of difficulty	No difficulty	Some difficulty	A lot of difficulty	Cannot do at all
Preparing a hot meal				
Shopping for groceries				
Making phone calls				
Managing money				
Doing household chores				

**Question 81:** Does anyone ever help you with each of the following –  
**FOR EACH ACTIVITY TICK ONE BOX THAT APPLIES**

Help	Yes	No	Not applicable
Preparing a hot meal			
Shopping for groceries			
Making phone calls			
Managing money			
Doing household chores			

**Question 82:** This question asks for more information about help you may receive with any of these activities.

Not applicable/No help needed  **Go to Q. 86**

If you do receive help, **who supports** you with this activity/these activities?

Please tick all that apply

Spouse/Partner/Boyfriend/Girlfriend	<input checked="" type="checkbox"/>
Parent	<input type="checkbox"/>
Sibling	<input checked="" type="checkbox"/>
Grandparent	<input type="checkbox"/>
Aunt / Uncle	<input checked="" type="checkbox"/>
Cousin	<input type="checkbox"/>
Key worker / Support worker	<input checked="" type="checkbox"/>
Friend	<input type="checkbox"/>
Neighbour	<input checked="" type="checkbox"/>
Home help	<input type="checkbox"/>
Public health nurse	<input checked="" type="checkbox"/>
Nurse	<input type="checkbox"/>
Health care worker	<input checked="" type="checkbox"/>

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**Question 83:** How much help did [you/he/she] receive from this person (in hours and minutes per week) in a typical week?

Please record to the nearest 15 minute interval for each person who helps you

	Hrs	Mins
Spouse/Partner/Boyfriend/Girlfriend		
Parent		
Sibling		
Grandparent		

Aunt / Uncle		
Cousin		
Key worker / Support worker		
Friend		
Neighbour		
Home help		
Public health nurse		
Nurse		
Health care worker		
Don't know		
Other (Please specify)		

**Question 84:** Do you feel you need more help with any of these activities, e.g. preparing a hot meal; shopping for groceries; making a telephone call; managing money and paying bills?

Please tick one box only

Yes	<input type="checkbox"/>	Go to Q. 85
No	<input type="checkbox"/>	Go to Q. 86
Don't know	<input type="checkbox"/>	Go to Q. 86

**Question 85:** What help do you feel you need?

Don't know

<b>Question 86:</b>	<b>Any Other Information (Instrumental Activities of Daily Living):</b> <div data-bbox="395 259 1385 492" style="border: 1px solid black; height: 104px; width: 620px;"></div>
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## Functional limitations

**Question 87:**

You may not be able to do some of the activities listed below but please try to answer each question as best you can. Exclude any difficulties that you expect to last less than three months.

Please indicate the level of difficulty, if any, you have with each of the following activities –

**FOR EACH ACTIVITY TICK ONE BOX THAT APPLIES**

Level of difficulty	No difficulty	Some difficulty	A lot of difficulty	Cannot do at all
Walking 100 yards				
Walking several hundred yards (By yourself and not using any aids)				
Walking up to 10 steps without resting (By yourself and not using any aids):				
Running or jogging about 1.5 kilometres (1 mile)				
Sitting for about 2 hours				
Getting up from a chair after sitting for long periods				
Climbing several flights of stairs without resting				
Climbing one flight of stairs without resting				
Stooping, kneeling or crouching				
Reaching or extending your arms above shoulder level				
Pulling or pushing large objects like a living room chair				

	Lifting or carrying weights over 10 pounds (5 kilos) like a heavy bag of groceries					
	Picking up a small coin from a table					
<b>Question 88:</b>	<b>Any Other Information (Functional limitations)</b>  <div data-bbox="395 600 1385 833" style="border: 1px solid black; height: 100px; width: 100%;"></div>					

## N) Section N: Other questions

Please get your Carer/Key worker/Support person to complete this section

**Question 89:** Do you think the participant ever feels lonely?

Please tick one box

Yes	<input type="checkbox"/>	Go to Question 90
No	<input type="checkbox"/>	Go to Question 91
Don't know	<input type="checkbox"/>	Go to Question 91

(IDS-TILDA)

**Question 90:** If you think the participant feels lonely, how often do you think they feel lonely?

Most of the time	<input type="checkbox"/>
Some of the time	<input type="checkbox"/>
Hardly ever, never	<input type="checkbox"/>
Don't know	<input type="checkbox"/>

(IDS-TILDA)

## O) Section O: How did you find filling out the questionnaire

<b>Question 91:</b>	<p><b>How long did it take you to fill out this questionnaire?</b></p> <p>Please tick one box</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 80%;">Less than 30 minutes</td> <td style="width: 20%;"></td> </tr> <tr> <td>30 minutes – 1 hour</td> <td></td> </tr> <tr> <td>1 – 2 hours</td> <td></td> </tr> <tr> <td>2 -3</td> <td></td> </tr> </table>	Less than 30 minutes		30 minutes – 1 hour		1 – 2 hours		2 -3	
Less than 30 minutes									
30 minutes – 1 hour									
1 – 2 hours									
2 -3									
<b>Question 92:</b>	<p><b>In general, did you find it easy to understand the questions?</b></p> <p>Please tick one box</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 80%;">Yes</td> <td style="width: 20%;"></td> </tr> <tr> <td>No</td> <td></td> </tr> <tr> <td>Don't know</td> <td></td> </tr> </table>	Yes		No		Don't know			
Yes									
No									
Don't know									
<b>Question 93:</b>	<p><b>Please tell us which questions did you find most difficult to understand?</b></p> <div style="border: 1px solid black; height: 80px; width: 100%;"></div>								
<b>Question 94:</b>	<p><b>Please tell us if you have any other comments about the questionnaire?</b></p> <div style="border: 1px solid black; height: 80px; width: 100%;"></div>								

<b>Question 95:</b>	<b>Has anyone supported you to fill out this questionnaire?</b> Please tick one box <table border="1" data-bbox="411 302 911 474"> <tr> <td>Yes</td> <td><input type="checkbox"/></td> </tr> <tr> <td>No</td> <td><input type="checkbox"/></td> </tr> <tr> <td>Don't know</td> <td><input type="checkbox"/></td> </tr> </table>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Don't know	<input type="checkbox"/>				
Yes	<input type="checkbox"/>										
No	<input type="checkbox"/>										
Don't know	<input type="checkbox"/>										
<b>Question 96:</b>	<b>Name of the person supporting you</b>  First Name _____ Surname _____										
<b>Question 97:</b>	<b>Is this the same person who gave you support in the previous interview?</b>  <table border="1" data-bbox="411 887 911 1059"> <tr> <td>Yes</td> <td><input type="checkbox"/></td> </tr> <tr> <td>No</td> <td><input type="checkbox"/></td> </tr> <tr> <td>Don't know</td> <td><input type="checkbox"/></td> </tr> </table>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Don't know	<input type="checkbox"/>				
Yes	<input type="checkbox"/>										
No	<input type="checkbox"/>										
Don't know	<input type="checkbox"/>										
<b>Question 98:</b>	<b>What is their relationship to you?</b>  <table border="1" data-bbox="411 1189 991 1473"> <tr> <td>Boyfriend/Girlfriend/Partner</td> <td><input type="checkbox"/></td> </tr> <tr> <td>Parent</td> <td><input type="checkbox"/></td> </tr> <tr> <td>Sibling</td> <td><input type="checkbox"/></td> </tr> <tr> <td>Key worker/Support worker</td> <td><input type="checkbox"/></td> </tr> <tr> <td>Friend</td> <td><input type="checkbox"/></td> </tr> </table> <div data-bbox="411 1529 1410 1715" style="border: 1px solid black; padding: 5px;">         Other (Please tell us)       </div>	Boyfriend/Girlfriend/Partner	<input type="checkbox"/>	Parent	<input type="checkbox"/>	Sibling	<input type="checkbox"/>	Key worker/Support worker	<input type="checkbox"/>	Friend	<input type="checkbox"/>
Boyfriend/Girlfriend/Partner	<input type="checkbox"/>										
Parent	<input type="checkbox"/>										
Sibling	<input type="checkbox"/>										
Key worker/Support worker	<input type="checkbox"/>										
Friend	<input type="checkbox"/>										

<b>Question 99:</b>	<b>How long do you know the person supporting you?</b>	
	Less than 6 months	
	Between 6 months & a year	
	More than a year	
	Don't know	

**THANK YOU VERY MUCH FOR TAKING THE TIME TO FILL IN THIS QUESTIONNAIRE.**

**PLEASE BRING IT WITH YOU TO YOUR INTERVIEW AND GIVE IT TO THE INTERVIEWER.**