UNIKLINIK KÖLN | Zentrum für Palliativmedizin

UNIKLINIK KÖLN | Klinik und Poliklinik für Neurologie

Cost booklet the study „**Co**mmunication, **Co**ordination and **S**ecurity for people with **M**ultiple **S**clerosis (**COCOS-MS**)“

Please enter *(if known):*

EDSS score: _____ **MS progression:** _____

Severely disabled: ❍ yes ❍ no

If yes, **since when?** _____

If yes, **degree of disability:** _____

Care level: ❍ yes ❍ no

If yes, which one: ❍ 1 ❍ 2 ❍ 3 ❍ 4 ❍ 5

OUTPATIENT TREATMENT / EXAMINATION / CONSULTATION APPOINTMENTS (in the past three months)

Did the patient see physicians / therapists of different disciplines?

❍ yes ❍ no

If yes, please checkmark and provide date:

	Date	**Date**	**Date**
A) Physicians of different disciplines			
❍ General physician			
❍ Internal physician, specify, if applicable: ❍ Gastroenterologist ❍ Cardiologist ❍ Hamatologist ❍ Oncologist			
❍ Neurologist			

❍ MS special outpatient clinic			
❍ Psychiatrist			
❍ Urologist			
❍ Gynecolgist			
❍ Ophthalmologist			
❍ Orthopaedist			
❍ Dermatologist			
❍ Pain physician			
❍ Palliative care physician			
B) Therapists			
❍ Occupational therapist			
❍ Speech therapist			
❍ Physiotherapist			
❍ Psychotherapist			
❍ Alternative practitioner			
❍ Osteopath			
C) Other medical services (e.g. opticians)			
❍ _____			

_____ _____			

INPATIENT TREATMENT (in the past three months)

A) Was an inpatient stay necessary?

❍ yes ❍ no

If yes, please checkmark and provide length of stay:

	Hospital ward
❍ Hospital	❍ General ward ❍ ICU *Reason for ICU:* _____

If yes, **from** |__|__|-|__|__|-|__|__|__|__| (D D - M M - Y Y Y Y) **to** |__|__|-|__|__|-|__|__|__|__| (D D - M M - Y Y Y Y)

Co-payment: _____

from |__|__|-|__|__|-|__|__|__|__| (D D - M M - Y Y Y Y) **to** |__|__|-|__|__|-|__|__|__|__| (D D - M M - Y Y Y Y)

Co-payment: _____

from |__|__|-|__|__|-|__|__|__|__| (D D - M M - Y Y Y Y) **to** |__|__|-|__|__|-|__|__|__|__| (D D - M M - Y Y Y Y)

Co-payment: _____

❍ Rehabilitation facility

If yes, **from** |__|__|-|__|__|-|__|__|__|__| (D D - M M - Y Y Y Y) **to** |__|__|-|__|__|-|__|__|__|__| (D D - M M - Y Y Y Y)

Co-payment: _____

from D D - M M - Y Y Y Y **to** D D - M M - Y Y Y Y

Co-payment: _____

from D D - M M - Y Y Y Y **to** D D - M M - Y Y Y Y

Co-payment: _____

❍ Nursing home

If yes: ❍ full institutional care ❍ short-term nursing care

If yes, **from** D D - M M - Y Y Y Y **to** D D - M M - Y Y Y Y

Co-payment: _____

from D D - M M - Y Y Y Y **to** D D - M M - Y Y Y Y

Co-payment: _____

from D D - M M - Y Y Y Y **to** D D - M M - Y Y Y Y

Co-payment: _____

❍ Similar accomodation: _____

If yes, **from** D D M M Y Y Y Y **to** D D - M M - Y Y Y Y

Co-payment: _____

from **to**

D D - M M - Y Y Y Y D D - M M - Y Y Y Y

Co-payment: _____

B) Was a stay in a day clinic necessary?

❍ yes ❍ no

If yes, please checkmark and provide length of stay:

from **to**

D D - M M - Y Y Y Y D D - M M - Y Y Y Y

Co-payment: _____

from **to**

D D - M M - Y Y Y Y D D - M M - Y Y Y Y

Co-payment: _____

from **to**

D D - M M - Y Y Y Y D D - M M - Y Y Y Y

Co-payment: _____

(DIAGNOSTIC) EXAMINIATIONS (in the past three months)

Were diagnostic examinations necessary?

❍ yes ❍ no

If yes, please checkmark and provide date:

	Date	**Date**	**Date**
❍ ECG			
❍ EEG			

❍ Diagnostic X-ray			
❍ Electrophysiological examinations (EMG; NCS)			
❍ Magnetic resonance imaging (MRI)			
❍ Computer tomography (CT)			
❍ Lumbar puncture			
❍ Ultrasound scan			
❍ Other: _____ _____			

PATIENT'S CURRENT MEDICATION LIST

	Medication (active ingredient)	Daily dose [mg]	Administration *1;2;3;4;5	Start of medication			End of medication	
				Prior to study	During the study (date) (DD/MM/YYYY)	See previous assessment**	Date (DD/MM/YYYY)	or ongoing
1	Glatiramer acetate			❑	__ __/__ __/__ __ __ __	❑	__ __/__ __/__ __ __ __	❑
2	Interferon-β 1a			❑	__ __/__ __/__ __ __ __	❑	__ __/__ __/__ __ __ __	❑
3	Interferon-β 1b			❑	__ __/__ __/__ __ __ __	❑	__ __/__ __/__ __ __ __	❑
4	Alemtuzumab			❑	__ __/__ __/__ __ __ __	❑	__ __/__ __/__ __ __ __	❑
5	Natalizumab			❑	__ __/__ __/__ __ __ __	❑	__ __/__ __/__ __ __ __	❑
6	Fingolimod			❑	__ __/__ __/__ __ __ __	❑	__ __/__ __/__ __ __ __	❑
7	Siponimod			❑	__ __/__ __/__ __ __ __	❑	__ __/__ __/__ __ __ __	❑
8	Ozanimod			❑	__ __/__ __/__ __ __ __	❑	__ __/__ __/__ __ __ __	❑
9	Ocrelizumab			❑	__ __/__ __/__ __ __ __	❑	__ __/__ __/__ __ __ __	❑
10	Rituximab			❑	__ __/__ __/__ __ __ __	❑	__ __/__ __/__ __ __ __	❑
11	Ofatumumab			❑	__ __/__ __/__ __ __ __	❑	__ __/__ __/__ __ __ __	❑
12	Cladribine			❑	__ __/__ __/__ __ __ __	❑	__ __/__ __/__ __ __ __	❑

13	Dimethyl fumarate			❑	__ __ /__ __ /__ __ __ __	❑	__ __ /__ __ /__ __ __ __	❑
14	Teriflunomide			❑	__ __ /__ __ /__ __ __ __	❑	__ __ /__ __ /__ __ __ __	❑
15	Mitoxantrone			❑	__ __ /__ __ /__ __ __ __	❑	__ __ /__ __ /__ __ __ __	❑
16	High-dose cortisone			❑	__ __ /__ __ /__ __ __ __	❑	__ __ /__ __ /__ __ __ __	❑
	Other: _____ _____							

***** 1 = p.o. (oral administration, by mouth)

2 = s.c. (subcutaneous administration)

3 = i.v. (intravenous administration, into the vein)

4 = i.m. (intramuscular administration, into the muscle)

5 = other

****** if date already entered there

OTHRE MEDICATION (in the past three months)

Were other drugs (e.g., antihypertensive agents, lipid-lowering drugs), for example to alleviate symptoms, prescribed or purchased?

❍ yes ❍ no

If yes, please checkmark and specify:

Reason	**Name**	**Dose / quantity**	**Package size**	**Self (co-)payment**
❍ Spasticity				
❍ Pain				
❍ Cognition				
❍ Urological complaints				
❍ Fatigue / exhaustion				
❍ Insomnia				
❍ Depression				
❍ Other: _____ _____ _____				

MEDICAL AIDS AND ADJUSTMENTS AT HOME (in the past three months)

Are medical aids necessary?

❍ yes ❍ no

Are adjustments made at home and / or regarding the means of transportation?

❍ yes ❍ no

If yes, please checkmark and describe:

	Description	**Price in €**	**Co-payment**
❍ Walking aids			
❍ Visual aids			
❍ Wheelchair (manual)			
❍ Wheelchair (electric)			
❍ Adjustments at home			
❍ Adjustments in the car			
❍ Other: _____ _____			
❍ _____ _____			

CARE, ASSISTANCE AND TRANSPORT (in the past three months)

Is care or assistance required for daily activities and transport (for example to treatment facilities)?

❍ yes ❍ no

If yes, please checkmark and describe in accordance with specifications:

	Explanation *(Exact description, distance in km from relative to patient)*	**Hours per day** *(for care)*	**Price in €** *(for professional service co-payment from insurance, if applicable)*
CARE			
❍ Help from family / relative			
❍ Professional nursing care			
❍ Other: _____ _____			

TRANSPORT TO USE HEALTH CARE SERVICES (in the past three months)

	Distance *in km from caregiver to treatment facility*	**Hours**	**Price in €**
❍ Taxi			
❍ Care taxi			
❍ Transport by caregiver			
❍ Patient transport			

EMERGENCY SERVICES (in the past three months)

Did an emergency service have to be called?

❍ yes ❍ no

If yes, please checkmark and provide date:

	Date	**Date**	**Date**
❍ Ambulance			
❍ Medical emergency service			
❍ Emergency practice			
❍ Emergency department			

WORK ABSCENCES (in the past three months)

Current or (previous) occupation: _____

❍ employed ❍ self-employed

Is the patient still able to work?

❍ yes ❍ no

If yes, then continue to table **A)**; *if no,* then continue to table **B)**

A)

Does the illness lead to missing working hours?

❍ yes ❍ no

If yes, please checkmark in the table below and quantify:

	Hours missed per day	**Explanation or exact reason**
❍ short-term		
❍ long-term *(starting from 6 weeks)*		

B)

Please checkmark the appropriate status:

1) ❍ incapacitated * ❍ unemployable **

Since when: _____

2) ❍ fully retired ❍ reduction in earning capacity

Since when: _____

** **previous** occupation can no longer be pursued*

*** neither previous occupation nor any other profession can be pursued*