**PLEASE COMPLETE ITEMS IN THIS SECTION ONCE**

**Your Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |
| --- | --- |
| **A1. Age**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**A2. Gender**:⭘ Female ⭘ Male ⭘Transgender ⭘ Non-Binary ⭘ Other**A3. Race/Ethnicity: (select all that apply)**🞎 White Non-Hispanic 🞎 Hispanic 🞎 Black/African American 🞎 Asian 🞎 American Indian/Alaska Native 🞎 Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_🞎 Native Hawaiian/Pacific Islander **A4. Are you currently employed?** ⭘ Full time (35+ hrs/wk) ⭘ Part time (<35 hrs/wk) ⭘ Leave of absence ⭘ Not employed ⭘ Retired**A5. I am providing care to my:**⭘ Parent ⭘ Spouse/Partner ⭘ Child/Child-in-law ⭘ Sibling ⭘ Other relative: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ⭘ Non-relative: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**A6. How long have you been the caregiver?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_**A7. Do you and the person you are caring for live in the same place?** ⭘ Yes, live together ⭘ No, live separately***If NO, do they live in a facility?*** ⭘ Yes ⭘ No | **A8. On average, how many days per week do you provide care? \_\_\_\_\_\_\_\_\_\_\_\_\_****A9. On the days you provide care, on average, how many hours per day do you provide care?** ⭘ <5 hrs/day ⭘ 5-15 hrs/day ⭘ 15+ hrs/day**A10. I provide the following types of care: (select all that apply)**🞎 Personal care (example: bathing, dressing, eating) 🞎 Daily tasks (example: cleaning, meal prep, errands, transportation)🞎 Managing medications🞎 Coordinating care (example: making appointments, going to medical visits, communicating with health care providers)🞎 Monitoring for symptoms and safety 🞎 Emotional support 🞎 Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**A11. Do you receive any financial compensation for the care you provide?**⭘ Yes, please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ⭘ No**A12. Are you providing care for anyone else at this time? }**⭘ Yes ⭘ No***If YES, who else are you providing care to? \_\_\_\_\_\_\_\_\_\_\_\_\_\_*** |

**PLEASE COMPLETE ITEMS AT EACH VISIT**

**Your Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**B1. How supported do you feel in the care you are providing?**

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Not at all supported (0) | 1 | 2 | 3 | 4 | Moderately supported (5) | 6 | 7 | 8 | 9 | Extremely supported (10) |
| ⭘ | ⭘ | ⭘ | ⭘ | ⭘ | ⭘ | ⭘ | ⭘ | ⭘ | ⭘ | ⭘ |

**B2. On a scale from 0-10, what has been your level of distress about your caregiving role during the past week?**

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Not at all distresed (0) | 1 | 2 | 3 | 4 | Moderately distressed (5) | 6 | 7 | 8 | 9 | Extremely distressed (10) |
| ⭘ | ⭘ | ⭘ | ⭘ | ⭘ | ⭘ | ⭘ | ⭘ | ⭘ | ⭘ | ⭘ |

**B3. Check all that have been a problem for you over the past week**:

|  |  |
| --- | --- |
| KNOWLEDGE AND SKILLS*Lack of information and/or skills about the patient’s…*🞎 Health condition🞎 Medications🞎 Nutrition🞎 Navigating health care 🞎 Planning for the future 🞎 Helping make healthcare decisions🞎 Connecting with community resources HEALTH AND WELLNESS🞎 I worry my own health has worsened due to providing care 🞎 Spiritual concerns (example: facing mortality, loss in faith, meaning in life)🞎 Intimacy or sexuality🞎 Interacting with the person I care for | EMOTIONAL *Over the past week, I have had feelings of…*🞎 Isolation or loneliness 🞎 Worry or anxiety🞎 Not knowing how to best provide care🞎 Anger or frustration 🞎 Sadness or depression🞎 Feeling overwhelmed or exhausted  PRACTICAL🞎 Transportation🞎 Housing or living arrangements🞎 Insurance coverage🞎 Food🞎 Work🞎 Financial concerns |

**B4. What are your main 1-3 concerns?**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**B5. What are your current sources of support? (example: friends, spirituality, activities)**

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| --- |
| **FOR CLINICIAN USE****Date**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Patient ID** (e.g. MRN): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Patient primary disease**: |
| 🞎 Cancer🞎 Hematology🞎 Cardiac🞎 Pulmonary🞎 Vascular | 🞎 Complex chronic conditions/ failure to thrive 🞎 Trauma🞎 Congenital/chromosomal conditions🞎 Gastrointestinal🞎 Hepatic | 🞎 Infectious/immunological/HIV 🞎 In-utero complication/condition🞎 Neurologic/stroke🞎 Dementia🞎 Other🞎 Unknown |
| **Project ID** (assigned): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**How was survey administered?**⭘ In-person ⭘ Email/Fax/Regular Mail ⭘ Phone ⭘ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **If in-person, did caregiver fill out the survey themselves?**⭘ Yes ⭘ No **Other notes:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |