**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:**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |