

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

WAVE 2 PRE-INTERVIEW QUESTIONNAIRE: CONFIDENTIAL

IDS-TILDA ID
Number:

W 2

Gender:

Male

1

Female

2

Interview Date:

D D / M M / Y Y

Interviewer ID
Number

I D S



IDS-TILDA

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

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 principle investigator of IDS-TILDA ©

INSTRUCTIONS

This questionnaire is part of WAVE 2 of The Intellectual Disability Supplement to TILDA. Thank you for taking part in this study. Your answers are very important to us to help ensure the needs of people with an intellectual disability are met as they grow older.

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.

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

HOW TO RETURN THIS QUESTIONNAIRE

Please give the questionnaire to the interviewer on the day of your interview. If you have any questions about the questionnaire, please call us at 01 8963186 or 01 8963187.

THE FOLLOWING QUESTIONS WILL UPDATE OUR RECORDS SINCE YOUR LAST INTERVIEW.

What is your date of birth?

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

Are you ...?

PLEASE TICK ONE BOX

Single

	1
--	---

Living with a partner as if married

	2
--	---

With a partner but not living with him/her

	3
--	---

Married

	4
--	---

Separated

	5
--	---

Divorced

	6
--	---

Widowed

	7
--	---

Don't know

	98
--	----

Have you moved home/residence since your last interview?

PLEASE TICK ONE BOX

YES

	1
--	---

NO

	5
--	---

GO TO EYE HEALTH

If you have moved do you currently pay rent for your home/residence?

PLEASE TICK ONE BOX

YES

	1
--	---

NO

	5
--	---

Don't Know

	98
--	----

PLEASE TELL US ANY OTHER INFORMATION

--

If you live in rented accommodation which of the following best describes your rental situation?

PLEASE TICK ONE THAT APPLIES

Type of Rental Situation

Social Housing e.g. County council or Housing association ☐ ¹

Private Landlord ☐ ²

Rented from my Service Provider ☐ ³

None of the above ☐ ⁴

If none of the above, Please tell us your rental situation

Please tell us if it is adapted or not adapted to meet your needs

Adapted ☐ ¹

Not Adapted ☐ ²

Don't Know ☐ ⁹⁸

Do you have an individual tenancy agreement?

PLEASE TICK ONE BOX

YES ☐ ¹

NO ☐ ⁵

Don't Know ☐ ⁹⁸

WE WOULD LIKE TO ASK YOU SOME QUESTIONS ABOUT YOUR HEALTH TO SEE IF THERE HAVE BEEN ANY CHANGES SINCE YOUR LAST INTERVIEW.

EYE HEALTH



1. Has the doctor ever told you that you have age related macular degeneration?

PLEASE TICK ONE BOX

YES

☐ 1

NO

☐ 5

Don't Know

☐ 98

2. Has a doctor ever told you that you have glaucoma?

PLEASE TICK ONE BOX

YES

☐ 1

NO

☐ 5

Don't Know

☐ 98

3. Has a doctor ever told you that you have cataracts?

PLEASE TICK ONE BOX

YES

☐ 1

GO TO QUESTION 4

NO

☐ 5

GO TO QUESTION 5

Don't Know

☐ 98

GO TO QUESTION 5

4. Have you had cataract surgery?

PLEASE TICK ONE BOX

YES, in one eye ☐¹

YES, in both eyes ☐²

NO ☐⁵

Don't Know ☐⁹⁸

5. Has a doctor ever told you that you have any other eye diseases?

PLEASE TICK ONE BOX

YES ☐¹ GO TO QUESTION 6

NO ☐⁵ GO TO QUESTION 7

Don't Know ☐⁹⁸ GO TO QUESTION 7

6. Please tell us what other eye diseases the doctor has told you that you have?

HEART HEALTH



7. Has the doctor ever told you that you have any of these conditions?

TICK ALL THAT APPLY

High cholesterol ☐¹ GO TO QUESTION 8

A heart murmur ☐¹ GO TO QUESTION 9

An abnormal heart rhythm ☐¹ GO TO QUESTION 9

None of these ☐¹ GO TO QUESTION 9

Don't know ☐¹ GO TO QUESTION 9

8. Are you taking any tablets or pills for high cholesterol?

PLEASE TICK ONE BOX

YES ☐ ¹

NO ☐ ⁵

Don't Know ☐ ⁹⁸

9. Has a doctor ever told you that you have high blood pressure or hypertension?

PLEASE TICK ONE BOX

YES ☐ ¹ GO TO QUESTION 10

NO ☐ ⁵ GO TO QUESTION 11

Don't Know ☐ ⁹⁸ GO TO QUESTION 11

10. About how old were you when you were first told by the doctor that you had high blood pressure?

I was years old.

Don't know ☐ ⁹⁸

11. Has a doctor ever told you that you have angina?

PLEASE TICK ONE BOX

YES ☐ ¹ GO TO QUESTION 12

NO ☐ ⁵ GO TO QUESTION 14

Don't Know ☐ ⁹⁸ GO TO QUESTION 14

12. About how old were you when you were first told by a doctor that you had angina?

I was years old.

Don't Know ☐ ⁹⁸

13. Do you limit your usual activities because of your angina?

PLEASE TICK ONE BOX

YES ☐¹
NO ☐⁵
Don't Know ☐⁹⁸

14. Has the doctor ever told you that you have had a heart attack (including myocardial infarction [MI] or coronary thrombosis)?

PLEASE TICK ONE BOX

YES ☐¹ GO TO QUESTION 15
NO ☐⁵ GO TO QUESTION 18
Don't Know ☐⁹⁸ GO TO QUESTION 18

15. About how old were you when you were first told by a doctor that you had a heart attack (including myocardial infarction [MI] or coronary thrombosis)?

I was years old.

Don't know ☐⁹⁸

16. In what month and year was your most recent heart attack?

(For example..... 09 / 2011

/

Don't know ☐⁹⁸

17. About how many heart attacks has the doctor said you have had?

I have had heart attacks

Don't Know ☐⁹⁸

18. Have you ever had an angioplasty or stent?

PLEASE TICK ONE BOX

YES ☐ ¹ GO TO QUESTION 19

NO ☐ ⁵ GO TO QUESTION 20

Don't Know ☐ ⁹⁸ GO TO QUESTION 20

19. In what month and year was your last angioplasty or stent?

(For example..... 0 9 / 2 0 1 1

/

Don't know ☐ ⁹⁸

20. Have you ever had open heart surgery?

PLEASE TICK ONE BOX

YES ☐ ¹ GO TO QUESTION 21

NO ☐ ⁵ GO TO QUESTION 22

Don't Know ☐ ⁹⁸ GO TO QUESTION 22

21. In what month and year was your last open heart surgery?

(For example..... 0 9 / 2 0 1 1

/

Don't know ☐ ⁹⁸

22. Has the doctor ever told you that you have congestive heart failure?

PLEASE TICK ONE BOX

YES ☐¹ GO TO QUESTION 23

NO ☐⁵ GO TO QUESTION 24

Don't Know ☐⁹⁸ GO TO QUESTION 24

23. About how old were you when you were first told by a doctor that you had congestive heart failure?

I was years old.

Don't know ☐⁹⁸

24. Have you ever had education on how best to take care of/manage your heart health?

PLEASE TICK ONE BOX

YES ☐¹

NO ☐⁵

Don't Know ☐⁹⁸

25. Have you ever had education on healthy eating/nutrition?

PLEASE TICK ONE BOX

YES ☐¹

NO ☐⁵

Don't Know ☐⁹⁸

26. Has the doctor ever told you that you have diabetes or high blood sugar?

PLEASE TICK ONE BOX

YES ☐¹ GO TO QUESTION 27

NO ☐⁵ GO TO QUESTION 34

Don't Know ☐⁹⁸ GO TO QUESTION 34

27. About how old were you when you were first told by a doctor that you had diabetes or high blood sugar?

I was years old.

Don't know ⁹⁸

28. What type of diabetes do you have?

Type 1 (formerly called insulin-dependent diabetes)

¹

Type 2 (formerly called non-insulin dependent diabetes)

²

Don't know

⁹⁸

29. How often do you have your blood glucose levels checked
TICK ONE BOX ONLY

Before meals

¹

Daily

²

Weekly

³

Monthly

⁴

Never

⁵

Don't know

⁹⁸

Other Please tell us

30. Are you currently taking any tablets, pills or other medication that you swallow for diabetes?

PLEASE TICK ONE BOX

YES

¹

NO

⁵

Don't Know

⁹⁸

31. Do you currently inject insulin for diabetes?

PLEASE TICK ONE BOX

YES ☐ ¹

NO ☐ ⁵

Don't Know ☐ ⁹⁸

32. Has the doctor ever told you that you have any of the following conditions related to your diabetes?

TICK ALL THAT APPLY

Leg ulcer ☐ ¹

Protein in your urine ☐ ¹

Lack of feeling and tingling in your legs and feet due to nerve damage ☐ ¹

Damage to the back of your eye ☐ ¹

Damage to your kidneys ☐ ¹

No, none of these ☐ ¹

Don't know ☐ ¹

33. Have you ever had education on how best to take care of/manage your diabetes?

PLEASE TICK ONE BOX

YES ☐ ¹

NO ☐ ⁵

Don't Know ☐ ⁹⁸

34. Has the doctor ever told you that you have had a stroke?

PLEASE TICK ONE BOX

YES ☐ ¹ GO TO QUESTION 35

NO ☐ ⁵ GO TO QUESTION 38

Don't Know ☐ ⁹⁸ GO TO QUESTION 38

35. About how old were you when you were first told by a doctor that you had a stroke?

I was years old.

Don't know ⁹⁸

36. About how many strokes has the doctor said you have had?

I have had strokes.

Don't Know ⁹⁸

37. In what year was your most recent stroke?

(For example 2011)

Don't know ⁹⁸

38 Has the doctor ever told you that you have had a ministroke or TIA?

PLEASE TICK ONE BOX

YES ☐ ¹ GO TO QUESTION 39

NO ☐ ⁵ GO TO QUESTION 42

Don't Know ☐ ⁹⁸ GO TO QUESTION 42

39. About how old were you when you were first told by a doctor that you had a ministroke or TIA?

I was years old.

Don't know ⁹⁸

40. About how many ministrokes or TIAs has the doctor said you have had?

I have had strokes.

Don't know ⁹⁸

41. In what year was your most recent ministroke or TIA?

(For example 2011)

Don't know

₉₈

42. Has the doctor ever told you that you have any other heart trouble?

PLEASE TICK ONE BOX

YES

☐₁

GO TO QUESTION 43

NO

☐₅

GO TO QUESTION 45

Don't Know

☐₉₈

GO TO QUESTION 45

43. Please tell us what other heart trouble has the doctor told you that you have?

44. About how old were you when you were first told by a doctor that you had any other heart trouble?

I was years old.

Don't know

₉₈



Other Health Conditions

45. Has the doctor ever told you that you have any of the following chronic conditions?

PLEASE TICK ALL THAT APPLY

- | | |
|--|---------------------------------------|
| Asthma | ☐ ¹ |
| Stomach ulcers | ☐ ¹ |
| Varicose ulcers (an ulcer due to varicose veins) | ☐ ¹ |
| Cirrhosis, or serious liver damage | ☐ ¹ |
| Constipation | ☐ ¹ |
| Coeliac disease | ☐ ¹ |
| Phenylketonuria (PKU) | ☐ ¹ |
| Hypothyroidism | ☐ ¹ |
| Hyperthyroidism | ☐ ¹ |
| Gastroesophageal reflux disease (like heartburn) | ☐ ¹ |
| Osteoporosis, sometimes called thin or brittle bones | ☐ ¹ |
| Multiple sclerosis | ☐ ¹ |
| Cerebral palsy | ☐ ¹ |
| Scoliosis | ☐ ¹ |
| Muscular dystrophy | ☐ ¹ |
| Spina bifida | ☐ |
| None of these | ☐ ¹ |
| Don't know | ☐ ¹ |

46. Has the doctor ever told you that you have any other chronic conditions?

PLEASE TICK ONE BOX

YES ☐ ₁ GO TO QUESTION 47

NO ☐ ₅ GO TO QUESTION 48

Don't Know ☐ ₉₈ GO TO QUESTION 48

47. Please tell us what other chronic conditions the doctor told you that you have?

CHRONIC LUNG DISEASE



48. Has the doctor ever told you that you have chronic lung disease such as chronic bronchitis or emphysema?

PLEASE TICK ONE BOX

YES ☐ ₁ GO TO QUESTION 49

NO ☐ ₅ GO TO QUESTION 51

Don't Know ☐ ₉₈ GO TO QUESTION 51

49. Are you receiving oxygen for your lung condition?

PLEASE TICK ONE BOX

YES ☐ ₁

NO ☐ ₅

Don't Know ☐ ₉₈

50. Does your lung condition (breathing difficulty) limit your usual activities, such as household chores, work, social or leisure activities?

PLEASE TICK ONE BOX

- YES ☐ ¹
- NO ☐ ⁵
- Don't Know ☐ ⁹⁸

ARTHRITIS



51. Has the doctor ever told you that you have arthritis (including osteoarthritis, or rheumatism)?

PLEASE TICK ONE BOX

- YES ☐ ¹ GO TO QUESTION 52
- NO ☐ ⁵ GO TO QUESTION 58
- Don't Know ☐ ⁹⁸ GO TO QUESTION 58

52. What type or types of arthritis do you have?

PLEASE TICK ALL THAT APPLY

- Osteoarthritis ☐ ¹
- Rheumatoid arthritis ☐ ¹
- Some other kind ☐ ¹
- Don't know ☐ ¹

53. About how old were you when you were first told by a doctor that you had arthritis?

I was years old.

Don't know ⁹⁸

54. Does your arthritis make it difficult for you to do your usual activities, such as household chores, work, social or leisure activities?

PLEASE TICK ONE BOX

Often/Always ☐ ¹

Sometimes ☐ ²

Never ☐ ³

Don't Know ☐ ⁹⁸

55. Does the arthritis limit your social and leisure activities?

PLEASE TICK ONE BOX

Often/Always ☐ ¹

Sometimes ☐ ²

Never ☐ ³

Don't Know ☐ ⁹⁸

56. Does your arthritis make it difficult for you to sleep at night?

PLEASE TICK ONE BOX

Often/Always ☐ ¹

Sometimes ☐ ²

Never ☐ ³

Don't Know ☐ ⁹⁸

57. Have you ever had education on how best to take care of/manage your bone health?

PLEASE TICK ONE BOX

YES

☐ ¹

NO

☐ ⁵

Don't Know

☐ ⁹⁸

CANCER



58. Has the doctor ever told you that you have cancer or a malignant tumour (including leukaemia or lymphoma but excluding minor skin cancers)?

PLEASE TICK ONE BOX

YES

☐ ¹

GO TO QUESTION 59

NO

☐ ⁵

GO TO QUESTION 67

Don't Know

☐ ⁹⁸

GO TO QUESTION 67

59. About how old were you when you were first told by a doctor that you had cancer or a malignant tumour?

I was years old.

Don't know

☐ ⁹⁸

60. In which organ or part/s of the body have you or had you cancer?

PLEASE TICK ALL THAT APPLY

Lung

☐ ¹

Breast

☐ ¹

Colon or rectum

☐ ¹

Stomach

☐ ¹

Oesophagus	☐ 1
Prostate	☐ 1
Bladder	☐ 1
Liver	☐ 1
Brain	☐ 1
Ovary	☐ 1
Cervix	☐ 1
Endometrium	☐ 1
Thyroid	☐ 1
Kidney	☐ 1
Testicle	☐ 1
Pancreas	☐ 1
Malignant melanoma (skin)	☐ 1
Non malignant melanoma	☐ 1
Oral cavity	☐
Larynx	☐ 1
Other Pharynx	☐ 1
Non-Hodgkin Lymphoma	☐ 1
Leukaemia	☐ 1
Other organ	☐ 1
Don't know	☐ 1

61. Have you received any treatment for your cancer?

PLEASE TICK ONE BOX

- | | | | |
|------------|--------------------------|---------------|-------------------|
| YES | ☐ | ¹ | GO TO QUESTION 62 |
| NO | ☐ | ⁵ | GO TO QUESTION 66 |
| Don't Know | ☐ | ⁹⁸ | GO TO QUESTION 66 |

62 What sort of treatment have you received for your cancer?

PLEASE TICK ALL THAT APPLY

- | | | |
|---|--------------------------|--------------|
| Chemotherapy | ☐ | ¹ |
| Medication | ☐ | ¹ |
| Surgery | ☐ | ¹ |
| Radiotherapy/ X-ray | ☐ | ¹ |
| Treatment of symptoms
(pain, nausea, rashes) | ☐ | ¹ |
| Biopsy | ☐ | ¹ |
| None of these | ☐ | ¹ |
| Don't know | ☐ | ¹ |

63. Have you had other sorts of treatment for your cancer?

PLEASE TICK ONE BOX

- | | | | |
|------------|--------------------------|---------------|-------------------|
| YES | ☐ | ¹ | GO TO QUESTION 64 |
| NO | ☐ | ⁵ | GO TO QUESTION 66 |
| Don't Know | ☐ | ⁹⁸ | GO TO QUESTION 66 |

64. Please tell us what other sort of treatments have you received from your cancer?

65. Since treatment has the cancer gotten better, or is it about the same or worse?

PLEASE TICK ONE BOX

Better ☐¹ GO TO QUESTION 67

About the same ☐² GO TO QUESTION 67

Worse ☐³ GO TO QUESTION 67

Don't Know ☐⁹⁸ GO TO QUESTION 67

66. Why have you **not** received treatment? Please tell us,



Parkinson's disease

67. Has the doctor ever told you that you have Parkinson's disease?

PLEASE TICK ONE BOX

YES ☐ ¹ GO TO QUESTION 68

NO ☐ ⁵ GO TO QUESTION 69

Don't Know ☐ ⁹⁸ GO TO QUESTION 69

68. About how old were you when you were first told by a doctor that you had Parkinson's disease?

I was years old.

Don't know ☐ ⁹⁸

Mental Health



69. Has the doctor ever told you that you have an emotional, nervous or psychiatric condition?

PLEASE TICK ONE BOX

YES ☐ ¹ GO TO QUESTION 70

NO ☐ ⁵ GO TO QUESTION 75

Don't Know ☐ ⁹⁸ GO TO QUESTION 75

70. What type of emotional, nervous or psychiatric condition(s) do you have?

PLEASE TICK ALL THAT APPLY

Hallucinations ☐ ¹

Anxiety ☐ ¹

Depression ☐ ¹

Emotional problems ☐ ¹

Schizophrenia ☐ ¹

Psychosis ☐ ¹

Mood swings ☐ ¹

Manic depression ☐ ¹

None of these ☐ ¹

Don't know ☐ ¹

Other ☐ ¹

If Other, Please tell us

71 Do you now get psychiatric treatment for your condition(s) such as attending a psychiatrist?

PLEASE TICK ONE BOX

YES ☐ ¹ GO TO QUESTION 72

NO ☐ ⁵ GO TO QUESTION 73

Don't Know ☐ ⁹⁸ GO TO QUESTION 73

72. Who gives you psychiatric treatment for your conditions?

PLEASE TICK ALL THAT APPLY

Please tell us the address where you see this person (this is required to calculate the distance you have to travel).

Psychiatrist

☐ ¹

General Practitioner

☐ ¹

Other (please tell us)

☐ ¹

Don't Know

☐ ¹

73. Do you now get psychological treatment for your condition(s), such as counselling or behaviour support?

PLEASE TICK ONE BOX

YES

☐ ¹ GO TO QUESTION 74

NO

☐ ⁵ GO TO QUESTION 75

Don't Know

☐ ⁹⁸ GO TO QUESTION 75

74. Who gives you psychological treatment for your condition(s)?

PLEASE TICK ALL THAT APPLY

Please tell us the address where you see this person (this is required to calculate the distance you have to travel).

Psychologist

☐ ¹

Counsellor

☐ ¹

Clinical Nurse Specialist (CNS)

☐ ¹

Other (please tell us)

☐ ¹

Don't Know

☐ ¹

75. Do you ever become annoyed, frustrated, or angry when things don't work out the way you want them?

PLEASE TICK ONE BOX

YES ☐ ¹ GO TO QUESTION 76

NO ☐ ⁵ GO TO QUESTION 77

Don't Know ☐ ⁹⁸ GO TO QUESTION 77

76. If Yes, what do you do

PLEASE TICK ALL THAT APPLY

Do nothing/don't react ☐ ₁

Scream ☐ ₁

Throw things ☐ ₁

Hit out ☐ ₁

Self injure ☐ ₁

Other ☐ ₁

If Other, Please tell us

77. Has a doctor ever told you that you have Alzheimer's disease?

PLEASE TICK ONE BOX

YES ☐¹ GO TO QUESTION 78

NO ☐⁵ GO TO QUESTION 79

Don't Know ☐⁹⁸ GO TO QUESTION 79

78. About how old were you when you were first told by a doctor that you had Alzheimer's disease?

I was years old

Don't know ☐⁹⁸

79. Has the doctor ever told you that you have dementia, organic brain syndrome or senility?

PLEASE TICK ONE BOX

YES ☐¹ GO TO QUESTION 80

NO ☐⁵ GO TO QUESTION 81

Don't Know ☐⁹⁸ GO TO QUESTION 81

80. About how old were you when you were first told by a doctor that you had dementia, organic brain injury or senility?

I was years old

Don't know ☐⁹⁸



81. Has the doctor ever told you that you have epilepsy?

PLEASE TICK ONE BOX

YES ☐ ¹ GO TO QUESTION 82

NO ☐ ⁵ GO TO QUESTION 93

Don't Know ☐ GO TO QUESTION 93

82. About how old were you when you were first told by a doctor that you had epilepsy?

I was years old.

Don't know ⁹⁸

83. What type of epilepsy do you have?

TICK ALL THAT APPLY

Tonic-clonic seizures ☐ ¹

Tonic seizures ☐ ¹

Atonic seizures ☐ ¹

Clonic seizures ☐ ¹

Myoclonic seizures ☐ ¹

Absence seizures ☐ ¹

Simple partial seizures ☐ ¹

Complex partial seizures ☐ ¹

Don't know ☐ ¹

84. Do/ Did you attend an Epilepsy clinic or see a specialist?

PLEASE TICK ONE BOX

- YES ☐ ¹
- NO ☐ ⁵
- Don't Know ☐ ⁹⁸

85 When did you last have your epilepsy reviewed (e.g. medication or seizure activity)?

- Last 12 months ☐ ¹
- Last 2 years ☐ ²
- More than 2 years ago ☐ ³
- Never ☐ ⁴
- I used to have epilepsy, I don't have seizures or take medication anymore ☐ ⁹⁴
- Don't know ☐ ⁹⁸

86. Who reviewed your epilepsy?

PLEASE TICK ALL THAT APPLY

- General Practitioner ☐ ¹
- Psychiatrist ☐ ¹
- Neurologist ☐ ¹
- CNS ☐ ¹
- Don't Know ☐ ¹
- Other ☐ ¹

If Other, Please tell us

87. Does your epilepsy limit any of the following...?

PLEASE TICK ALL THAT APPLY

- | | |
|-------------------|---------------------------------------|
| Household chores | ☐ ¹ |
| Work | ☐ ¹ |
| Social Activities | ☐ ¹ |
| Sports Activities | ☐ ¹ |
| Driving | ☐ ¹ |
| Going out alone | ☐ ¹ |
| None of the above | ☐ ¹ |
| Other | ☐ ¹ |

If Other, Please tell us

88. Are any of the following medication prescribed for you to use in an emergency (rescue medication)

PLEASE TICK ALL THAT APPLY

- | | | |
|------------------------------|---------------------------------------|--------------------------|
| Epistatus (Buccal Midazolam) | ☐ ¹ | GO TO QUESTION 89 |
| Frisium (Clobazam) | ☐ ¹ | GO TO QUESTION 89 |
| Stesolid (Rectal Diazepam) | ☐ ¹ | GO TO QUESTION 89 |
| Clonazepam (Rivotril) | ☐ ¹ | GO TO QUESTION 89 |
| Lorazepam (Ativan) | ☐ ¹ | GO TO QUESTION 89 |
| None | ☐ ¹ | GO TO QUESTION 93 |
| Don't Know | ☐ ¹ | GO TO QUESTION 93 |
| Other | ☐ ¹ | GO TO QUESTION 89 |

If Other, Please tell us

89. Have you used any of the emergency medications (rescue medication) in the last 12 months, If so please tell us?

Emergency Medication

Epistatus (Buccal Midazolam)	☐ ¹
Frisium (Clobazam)	☐ ¹
Stesolid (Rectal Diazepam)	☐ ¹
Clonazepam (Rivotril)	☐ ¹
Lorazepam (Ativan)	☐ ¹
None	☐ ¹
Don't Know	☐ ¹
Other	☐ ¹

If Other, Please tell us

90. Do you keep a record of your seizures?

PLEASE TICK ONE BOX

YES	☐ ¹
NO	☐ ⁵
Don't Know	☐ ⁹⁸

91. How often have you had a seizure in the past two years?

PLEASE TICK ONE BOX

Have not had a seizure in 2 years

☐ 1

Daily

☐ 2

Weekly (but not daily)

☐ 3

More than once a month (but not weekly)

☐ 4

Less than once a month

☐ 5

Don't Know

☐ 98

92. Have you ever had education on how best to take care of/manage your epilepsy?

PLEASE TICK ONE BOX

YES

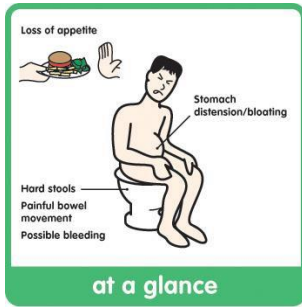
☐ 1

NO

☐ 5

Don't Know

98



Constipation

Constipation

93. Over the past 6 months have you experienced any of the following for at least 25% of defecations and have they been active for 3 months?

PLEASE TICK ALL THAT APPLY

- | | | |
|---|--------------------------|---|
| Straining | ☐ | 1 |
| Lumpy or hard stool | ☐ | 1 |
| Sensation of incomplete evacuation | ☐ | 1 |
| Sensation of anorectal obstruction/blockage | ☐ | 1 |
| Manual maneuvers (e.g. digital evacuation, support to the pelvic floor) | ☐ | 1 |
| Fewer than three defecations per week | ☐ | 1 |
| Pain during defecation | ☐ | 1 |

94. Do you ever have normal or loose stool without the use of laxatives?

PLEASE TICK ONE BOX

- | | | |
|------------|--------------------------|----|
| YES | ☐ | 1 |
| NO | ☐ | 5 |
| Don't Know | ☐ | 98 |

95. Have you ever been diagnosed with irritable bowel syndrome?

PLEASE TICK ONE BOX

- YES ☐ ¹
- NO ☐ ⁵
- Don't Know ☐ ⁹⁸

96. Have you ever experienced encopresis? By this we mean a small leakage of bowel movements which result in stained underwear

PLEASE TICK ONE BOX

- YES ☐ ¹
- NO ☐ ⁵
- Don't Know ☐ ⁹⁸

MEDICAL TESTS AND SCREENING



97. Have you had a flu injection?

PLEASE TICK ONE BOX

- YES ☐ ¹
- NO ☐ ⁵
- Don't Know ☐ ⁹⁸

98. Have you had the Hepatitis B vaccine?

PLEASE TICK ONE BOX

- YES ☐ ¹
- NO ☐ ⁵
- Don't Know ☐ ⁹⁸

99. Have you ever had a blood test for cholesterol?

PLEASE TICK ONE BOX

- YES, within the last 2 years ☐ ¹
- YES, over 2 years ago ☐ ²
- NO ☐ ⁵
- Don't Know ☐ ⁹⁸

100. Have you ever had your blood pressure measured?

PLEASE TICK ONE BOX

- YES, within the last 2 years ☐ ¹
- YES, over 2 years ago ☐ ²
- NO ☐ ⁵
- Don't Know ☐ ⁹⁸

101. Have you ever had a thyroid function test?

PLEASE TICK ONE BOX

- YES, within the last 2 years ☐ ¹
- YES, over 2 years ago ☐ ²
- NO ☐ ⁵
- Don't Know ☐ ⁹⁸

102. Have you ever had a blood glucose test (sugar test)?

PLEASE TICK ONE BOX

YES, within the last 2 years ☐ 1

YES, over 2 years ago ☐ 2

NO ☐ 5

Don't Know ☐ 98

103. Have you ever been screened or assessed for memory impairment/dementia?

PLEASE TICK ONE BOX

YES, within the last 2 years ☐ 1

YES, over 2 years ago ☐ 2

NO ☐ 5

Don't Know ☐ 98

104. Have you had a bone density test? (e.g. DEXA Scan)

PLEASE TICK ONE BOX

YES, within the last 2 years ☐ 1

YES, over 2 years ago ☐ 2

NO ☐ 5

Don't Know ☐ 98

105. Did your mother or father ever experience any of the following....?

PLEASE TICK ALL THAT APPLY

Hip fracture ☐ ¹

Colon cancer ☐ ¹

Breast cancer ☐ ¹

Dementia ☐ ¹

Don't Know ☐ ¹

106. Have you ever had any of the following tests?

PLEASE TICK ALL THAT APPLY

CT Brain Scan ☐ ¹

CT Scan (other than brain) ☐ ¹ Please tell us _____

MRI Brain scan ☐ ¹

MRI Scan (Other than brain) ☐ ¹ Please tell us _____

EEG ☐ ¹

Don't Know ☐ ¹

Women Only Questions



107. Have you gone through or are you currently going through the menopause?

PLEASE TICK ONE BOX

YES, gone through the menopause already ☐ ¹ GO TO QUESTION 108

YES, currently going through the menopause ☐ ² GO TO QUESTION 108

NO ☐ ⁵ GO TO QUESTION 112

Don't Know ☐ ⁹⁸ GO TO QUESTION 112

108. About how old were you when it started?

I was years old?

Don't know ☐ ⁹⁸

109. Since menopause have you used prescription hormones (e.g. HRT, estrogen)

PLEASE TICK ONE BOX

YES, currently taking hormones ☐ ¹ GO TO QUESTION 110

YES, but no longer taking hormones ☐ ² GO TO QUESTION 111

NO ☐ ⁵ GO TO QUESTION 112

Don't Know ☐ ⁹⁸ GO TO QUESTION 112

110. For how many years have you been taking prescription hormones?

(For example ... years)

For years GO TO QUESTION 112

Don't know ☐ ⁹⁸ GO TO QUESTION 112

111. For how many years did you take prescription hormones?

For years (For example 03 years)

Don't know 98

112. Do you check your breasts for lumps regularly?

PLEASE TICK ONE BOX

YES ☐1

NO ☐5

Don't Know ☐98

113. Has the GP or nurse checked your breasts for lumps?

PLEASE TICK ONE BOX

YES ☐1

NO ☐5

Don't Know ☐98

114. Have you had a mammogram or x-ray of the breast, to search for cancer?

PLEASE TICK ONE BOX

YES ☐1

NO ☐5

Don't Know ☐98

Men Only Questions



115. Do you check your testicles for lumps regularly?

PLEASE TICK ONE BOX

YES

☐ ¹

NO

☐ ⁵

Don't Know

☐ ⁹⁸

116. Has the GP checked your testicles for lumps?

PLEASE TICK ONE BOX

YES

☐ ¹

NO

☐ ⁵

Don't Know

☐ ⁹⁸

117. Have you had an examination of your prostate to screen for cancer?

PLEASE TICK ONE BOX

YES

☐ ¹

NO

☐ ⁵

Don't Know

☐ ⁹⁸

118. Have you had a blood test (PSA) to screen for prostate cancer?

PLEASE TICK ONE BOX

YES

☐ ¹

NO

☐ ⁵

Don't Know

☐ ⁹⁸

HEALTHCARE UTILISATION



119. Are you covered by any of the following?

PLEASE TICK ONE BOX

- Full medical card or equivalent ☐ 1
- GP visit card ☐ 2
- Neither of these ☐ 3
- Don't Know ☐ 98

120. Do you have private medical insurance cover (VHI etc) in your own name or through another family member?

PLEASE TICK ONE BOX

- Yes, in my own name ☐ 1
- Yes, as the spouse of a subscriber ☐ 2
- Yes, as the relative of a subscriber ☐ 3
- No ☐ 5
- Don't Know ☐ 98

121. In the last year, about how often did you visit your GP or did your GP visit you?

(For example ... visits)

- Number of visits
- Don't Know 98

122. In the last year, how many times did you visit a hospital Emergency Department (sometimes called A&E or Accident and Emergency) as a patient?

(For example ... visits)

Number of visits

Don't Know ⁹⁸

123. If you attended A&E for treatment in the last year, what was the reason?

PLEASE TICK ALL THAT APPLY

Has not visited A&E in last year ☐ ¹

Multiple injuries ☐ ¹

Broken or fractured bone(s) ☐ ¹

Burn(s) ☐ ¹

Dislocation(s) ☐ ¹

Sprain or strain(s) ☐ ¹

Cut(s) or Open wound ☐ ¹

Scrape, bruise, blister(s) ☐ ¹

Concussion or other head/brain injury ☐ ¹

Poisoning ☐ ¹

Internal injuries(s) ☐ ¹

Pneumonia ☐ ¹

Don't know ☐ ¹

Other ☐ ¹

If Other, Please tell us

124. In the last year, about how many visits did you make to a hospital out-patient clinic? Include all types of consultations, tests, operations, procedures or treatment

Number of visits (For example ... 0 3 visits)

Don't Know ⁹⁸

125. In the last year, how many nights did you spend in a general hospital?

Total number of nights (For example ... 0 1 nights)

Don't Know ⁹⁸

126. In the last year, how many nights did you spend in an acute/psychiatric hospital due to mental health problems?

PLEASE TICK ONE BOX

- Did not spend any nights ☐ ¹
- 1 to 5 nights ☐ ²
- 6 to 10 nights ☐ ³
- 11 to 20 nights ☐ ⁴
- More than 20 nights ☐ ⁵
- Don't know ☐ ⁹⁸

127. the last year, how much time did you spend in a nursing /convalescent home?

PLEASE TICK ONE BOX

- | | | |
|------------------------|--------------------------|---------------|
| Did not spend any time | ☐ | ¹ |
| One week or less | ☐ | ² |
| Up to 1 month | ☐ | ³ |
| Up to 2 months | ☐ | ⁴ |
| Up to 3 months | ☐ | ⁵ |
| More than 3 months | ☐ | ⁶ |
| Don't know | ☐ | ⁹⁸ |

128. During the last year, was there ever a time when you felt you needed healthcare but you didn't receive it?

PLEASE TICK ONE BOX

- | | | | |
|------------|--------------------------|---------------|--------------------|
| YES | ☐ | ¹ | GO TO QUESTION 129 |
| NO | ☐ | ⁵ | GO TO QUESTION 131 |
| Don't Know | ☐ | ⁹⁸ | GO TO QUESTION 131 |

129. Thinking of the most recent time, why did you **not** get healthcare?

PLEASE TICK ALL THAT APPLY

- | | |
|--|----------------------------|
| Healthcare was not offered | ☐ 1 |
| Not available in the area | ☐ 1 |
| Not available at the time required | ☐ 1 |
| Waiting time too long | ☐ 1 |
| Felt that the service would not be good | ☐ 1 |
| Too costly | ☐ 1 |
| Too busy | ☐ 1 |
| Didn't get around to it/didn't bother | ☐ 1 |
| Didn't know where to go | ☐ 1 |
| Problems with transport | ☐ 1 |
| Communications/language problems | ☐ 1 |
| Personal or family responsibilities | ☐ 1 |
| Fear of healthcare services and/or of treatment | ☐ 1 |
| Decided not to seek care | ☐ 1 |
| Information material not accessible /inadequate communication aids | ☐ 1 |
| Complaint was not taken seriously enough | ☐ 1 |
| Negative attitudes of the staff | ☐ 1 |
| Too embarrassing | ☐ 1 |
| I was in too much pain | ☐ 1 |
| I forgot about my appointments | ☐ 1 |

Don't know

☐

Other

☐

If Other, Please tell us

130. Again thinking of the most recent time, what was the type of care that was needed?

PLEASE TICK ALL THAT APPLY

Treatment of a physical health problem (e.g. cataract surgery

☐ ¹

Treatment of an emotional or mental health problem

☐ ¹

A regular check-up

☐ ¹

Care of an injury

☐ ¹

Don't know

☐ ¹

Other

☐ ¹

If Other, Please tell us

131. In the last year, did you receive any of the following services (exclude any service that you paid for yourself)? **If yes please tell us how satisfied you are with this service**

PLEASE TICK ALL THAT APPLY

			Very Satisfied		Satisfied		Not Satisfied	
General practitioner	☐	1	☐	1	☐	2	☐	3
Public health or community nurse	☐	1	☐	1	☐	2	☐	3
Occupational therapy	☐	1	☐	1	☐	2	☐	3
Chiropody services	☐	1	☐	1	☐	2	☐	3
Physiotherapy services	☐	1	☐	1	☐	2	☐	3
Social work services	☐	1	☐	1	☐	2	☐	3
Psychological/counselling services	☐	1	☐	1	☐	2	☐	3
Home help	☐	1	☐	1	☐	2	☐	3
Personal care attendant	☐	1	☐	1	☐	2	☐	3
Meals-on-wheels	☐	1	☐	1	☐	2	☐	3
Optician services	☐	1	☐	1	☐	2	☐	3
Dental services	☐	1	☐	1	☐	2	☐	3
Hearing services	☐	1	☐	1	☐	2	☐	3
Pharmacist	☐	1	☐	1	☐	2	☐	3
Dietician services	☐	1	☐	1	☐	2	☐	3
Speech & Language services	☐	1	☐	1	☐	2	☐	3
Day centre services	☐	1	☐	1	☐	2	☐	3
Respite services	☐	1	☐	1	☐	2	☐	3
Residential services	☐	1	☐	1	☐	2	☐	3

	Very							
	Satisfied		Satisfied		Satisfied		Not Satisfied	
Neurological services	☐	1	☐	1	☐	2	☐	3
Geriatrician services	☐	1	☐	1	☐	2	☐	3
Endocrinology services	☐	1	☐	1	☐	2	☐	3
Dermatological services	☐	1	☐	1	☐	2	☐	3
Psychiatry services	☐	1	☐	1	☐	2	☐	3
Palliative care services	☐	1	☐	1	☐	2	☐	3
Don't Know	☐	1	☐	1	☐	2	☐	3
Other	☐	1	☐	1	☐	2	☐	3

If Other, Please tell us

132. If you ticked 'not satisfied' for any of the above please tell us why you are not satisfied e.g. waiting list too long, cost, access to building is very difficult.

PLEASE STATE WHICH SERVICE YOU ARE REFERRING TO

133. In the last year, where did you receive any of the following services (exclude any service that you paid for yourself)? Tell us if you attended the health service in the community or in the service provider/ service setting.

PLEASE TICK ALL THAT APPLY

	Community Setting /Mainstream	Service Provider Setting
General practitioner	☐ 1	☐ 2
Public health or community nurse	☐ 1	☐ 2
Occupational therapy	☐ 1	☐ 2
Chiropody services	☐ 1	☐ 2
Physiotherapy services	☐ 1	☐ 2
Social work services	☐ 1	☐ 2
Psychological/counselling services	☐ 1	☐ 2
Home help	☐ 1	☐ 2
Personal care attendant	☐ 1	☐ 2
Meals-on-wheels	☐ 1	☐ 2
Optician services	☐ 1	☐ 2
Dental services	☐ 1	☐ 2
Hearing services	☐ 1	☐ 2
Pharmacist	☐ 1	☐ 2
Dietician services	☐ 1	☐ 2
Speech & Language services	☐ 1	☐ 2
Day centre services	☐ 1	☐ 2
Respite services	☐ 1	☐ 2

	Community Setting /Mainstream Services	Service Provider Setting
Residential services	☐ 1	☐ 2
Neurological services	☐ 1	☐ 2
Geriatrician services	☐ 1	☐ 2
Endocrinology services	☐ 1	☐ 2
Dermatological services	☐ 1	☐ 2
Psychiatry services	☐ 1	☐ 2
Palliative care services	☐ 1	☐ 2
Don't Know	☐ 1	☐ 2
Other	☐ 1	☐ 2

If Other, Please tell us

134. Are there any services that you think you would benefit from that you are not receiving at present?

PLEASE TICK ONE BOX

- YES ☐ 1 GO TO QUESTION 135
- NO ☐ 5 GO TO QUESTION 138
- Don't Know ☐ 98 GO TO QUESTION 138

135. Please tell us which services you think you would benefit from that you are not receiving at present?

PLEASE TICK ALL THAT APPLY

General practitioner	☐	1
Public health or community nurse	☐	1
Occupational therapy	☐	1
Chiropody services	☐	1
Physiotherapy services	☐	1
Social work services	☐	1
Psychological/counselling services	☐	1
Home help	☐	1
Personal care attendant	☐	1
Meals-on-wheels	☐	1
Optician services	☐	1
Dental services	☐	1
Hearing services	☐	1
Pharmacist	☐	1
Dietician services	☐	1
Speech & Language services	☐	1
Day centre services	☐	1
Respite services	☐	1
Residential services	☐	1
Neurological services	☐	1

Geriatrician services	☐	1
Endocrinology services	☐	1
Dermatological services	☐	1
Psychiatry services	☐	1
Palliative care services	☐	1
Don't Know	☐	1
Other	☐	1

If Other, Please tell us

136. Do you know how to access this service?

PLEASE TICK ONE BOX

YES ☐ 1

NO ☐ 5

Don't Know ☐ 98

137. Please tell us the main thing that stops/prevents you from receiving this service or services?

Don't Know ☐ 98

138. In the last year how many nights did you spend in respite (excluding nights spent in a nursing home)?

PLEASE TICK ONE

- | | | |
|--------------------------|--------------------------|----|
| Did not spend any nights | ☐ | 1 |
| 1 to 5 nights | ☐ | 2 |
| 6 to 10 nights | ☐ | 3 |
| 11 to 20 nights | ☐ | 4 |
| More than 20 nights | ☐ | 5 |
| Don't know | ☐ | 98 |

139. Have you ever received any easy to read information leaflets on any of the following....?

PLEASE TICK ALL THAT APPLY

- | | | | |
|--------------------------|--------------------------|---|---------------------------|
| Bone Health | ☐ | 1 | GO TO QUESTION 140 |
| Heart Health | ☐ | 1 | GO TO QUESTION 140 |
| Epilepsy | ☐ | 1 | GO TO QUESTION 140 |
| Diabetes | ☐ | 1 | GO TO QUESTION 140 |
| Exercise | ☐ | 1 | GO TO QUESTION 140 |
| Nutrition/Healthy Eating | ☐ | 1 | GO TO QUESTION 140 |
| Constipation | ☐ | 1 | GO TO QUESTION 140 |
| None of the above | ☐ | 1 | GO TO QUESTION 141 |
| Don't Know | ☐ | 1 | GO TO QUESTION 141 |

140. Please tell us who you received easy to read information from...

TICK ALL THAT APPLY

	Specialist	GP	Pharmacist	Public Health	Nurse	RNID	Other
Bone Health	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	
Heart Health	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	
Epilepsy	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	
Diabetes	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	
Exercise	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	
Nutrition/Healthy Eating	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	
Constipation	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	

If Other, please tell us

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

PLEASE TICK ONE BOX

YES ☐ 1 GO TO QUESTION 142

NO ☐ 5 GO TO QUESTION 143

Don't Know ☐ 98 GO TO QUESTION 143

**142. If Yes, from whom
PLEASE TICK ALL THAT APPLY**

- | | | |
|----------------------|--------------------------|---|
| General Practitioner | ☐ | 1 |
| Pharmacist | ☐ | 1 |
| Public Health Nurse | ☐ | 1 |
| RNID | ☐ | 1 |
| Don't Know | ☐ | 1 |
| Other | ☐ | 1 |

If Other, Please tell us

143. In the last year did you receive support from any of the following organisations?

PLEASE TICK ALL THAT APPLY

- | | | |
|--|--------------------------|---|
| The Society of St. Vincent de Paul | ☐ | 1 |
| The Senior Helpline | ☐ | 1 |
| The Samaritans | ☐ | 1 |
| No support from these organisations | | 1 |
| Don't Know | ☐ | 1 |
| Support from other excluding your service provider | | 1 |

If Other, Please tell us

144. MEDICATIONS



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

PLEASE WRITE DOWN ALL MEDICATIONS/TABLETS YOU TAKE AND HOW OFTEN YOU TAKE THEM, PLEASE USE ONE LINE PER MEDICATION

Don't know what medication I take, record by proxy

☐

¹ PLEASE COMPLETE MEDICATION FORM

Don't take any medication

¹ GO TO QUESTION 145

Name of Medication	Dosage Strength	Frequency	Route	Date First Prescribed
Examples of medication completion form :				
Epilim Chrono	200mgs	Twice a day (BD)	Orally(PO)	Sept 2009
One touch ultra test strip(blood glucose)	1 strip	Before meals	-	June 2010
Neo-cytamen Injection(hydroxycobalamin)	1000micrograms	Monthly	IM	Nov 2010
Xalatan eye drops	2 drops (left eye)	Nocte (At night)	Instill	June 2010
Emulsifying Ointment		PRN	Topically	Jan 2009
Vegepa (Omega fishoil)		2 daily	PO	June 2005
Ensure Plus		1 daily	PO	Oct 2007



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Name of Medication	Dosage Strength	Frequency	Route	Date Prescribed
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				
14				
15				
16				
17				
18				

Name of Medication	Dosage Strength	Frequency	Route	Date Prescribed
19				
20				
21				
22				
23				
24				

145. BLOOD TESTS

We would like to record all the blood tests you have had in the last year. This will help us build a picture of the changes older people experience over time. Please tell us the results of your most recent blood tests.

[Please indicate if bloods are **fasting or random**]

Did not get any blood tests in the last year

GO TO QUESTION 146

BLOOD TEST	DATE	RESULT	Fasting ₁ /Not Fasting ₅ (If Applicable) ₈₈₈	Normal Range
EXAMPLE: Calcium	14/3/2012	6.1mg		(Normal range 8.2 - 10.6 mg/dL)
FBC Red blood cells FBC White blood cells FBC Haemoglobin FBC Platelets				
ESR				
HbA1C				
BLOOD GLUCOSE				
U&E				
B ₁₂				



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BLOOD TEST	DATE	RESULT	Fasting₁ /Not Fasting₅ (If Applicable)₈₈₈	Normal Range
FOLATE				
LFTs				
SERUM CHOLESTEROL				
LIPID PROFILE				
VIT D (25-hydroxyvitamin D/1.25-hydroxyvitamin D)				
HEP SCREEN (A) HEP SCREEN (B) HEP SCREEN (C)				
TFTs				
CALCIUM				
PSA				

ANY OTHER PLEASE TELL US				
BLOOD TEST	DATE	RESULT	Fasting ₁ /Not Fasting ₅ (If Applicable) ₈₈₈	Normal Range

FILLING OUT THE QUESTIONNAIRE



146. How long did it take you to fill out this questionnaire?

PLEASE TICK ONE BOX

Less than 30 minutes ☐ ¹

30 minutes – 1 hour ☐ ²

1 – 2 hours ☐ ³

2 – 3 hours ☐ ⁴

More than 3 hours ☐ ⁵

Don't know ☐ ⁹⁸

147. In general, did you find it easy to understand the questions?

PLEASE TICK ONE BOX

YES ☐ ¹ GO TO QUESTION 149

NO ☐ ⁵ GO TO QUESTION 148

Don't Know ☐ ⁹⁸ GO TO QUESTION 149

148. Please tell us which questions did you find most difficult to understand?



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149. Please tell us if you have any other comments about the questionnaire?

150. Has anyone supported you to fill out this questionnaire?

PLEASE TICK ONE BOX

YES ☐ ¹ GO TO QUESTION 151

NO ☐ ⁵ **YOU ARE NOW FINISHED THANK YOU FOR YOUR TIME**

151. Name of the person supporting you

First name

Surname

152. Is this the same person who gave you support in the first interview?

PLEASE TICK ONE BOX

YES ☐ ¹

NO ☐ ⁵

153. What is their relationship to you?

- Boyfriend/Girlfriend/Partner ☐ 1
- Parent ☐ 2
- Sibling ☐ 3
- Key worker/ Support worker ☐ 4
- Friend ☐ 5
- Other ☐ 95

If Other, Please tell us

154. How long do you know the person supporting you?

PLEASE TICK ONE BOX

- Less than 6 months ☐ 1
- Between 6 months and a year ☐ 2
- More than a year ☐ 3
- Don't Know ☐ 98

**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**

DO NOT COPY

The Intellectual Disability Supplement to TILDA
The University of Dublin, Trinity College,
School of Nursing & Midwifery,
24 D'Olier Street, Dublin 2.

General Inquiries: 01-8963187

Email: dstilda@tcd.ie

www.idstilda.tcd.ie

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