PIADS Background Form -Mechanical Ventilation #____

Client Name: _____ Today's Date: _____
(first name then last name) month/day/year

Client Diagnosis:_____ Client Date of Birth: _____
month/day/year

Client Gender:_____ Client List ID (Office use) _____

The following information is helpful to us in understanding your responses to the other questionnaires. Please mark ( ) the responses that best describe your situation.

Important

If you are filling out this form on behalf of client or assistive device user please interpret questions referring to "you" and "I" as if this were the user. For instance if the question asks "how important do **you** feel the device is to **your** life", read this as "how important **does the user** feel the device is to **his/her** life".

Part A. The following questions are about the completion of this form.

1. Who is filling out this form? (mark one)
   a) Client
   b) Caregiver
   c) Researcher
   d) Healthcare Professional
   e) Other:_____

2. Who is providing the responses to this form? (mark one)
   a) Client
   b) Caregiver

3. How is this form being filled out? (mark one)
   a) Face to face
   b) E-mail
   c) Telephone
   d) Regular mail
   e) Other:_____

4. What is the profession of the individual who prescribed this device? (mark one)
   a) Medical Doctor
   b) Respiratory Therapist
   c) Other:_____

Part B. The following questions are about your general health.

1. Do you have any other assistive devices? (Mark all that apply)
   a) Hearing Aids (Please Specify Type) _____
   b) Vision Aids (Please Specify Type) _____
   c) ADL Aids (e.g. toilet seat, grab bars etc.) (Please Specify) _____
   d) Mobility Aids (Please Specify) _____
   e) Communication Device/Computer (Please Specify) _____
   f) Environmental Controls (Please Specify) _____

2. Have you been experiencing difficulty sleeping? **Yes** **No**

   If so, for how long? _____

3. Are you snoring at night (Sleep Apnea)? **Yes** **No**

4. Do you require suctioning? **Yes** **No**

   If so, how often? _____

5. Do you experience any of the following? (Mark all that apply)

stomach aches	ear pain	other (specify):
heartburn	sinus pain	_____
headaches	eye pain	no aches or pains

6. Can you breathe at all without Mechanical Ventilation? **Yes** **No**

   If so, for how long? _____

Part C. The following questions are about your breathing device.

1. I no longer use the breathing device because: (mark all that apply)
   a) My medical or physical condition has changed.
   b) I have switched to a different kind of breathing device.
   c) Date you changed device _____ (month/day/year)
   d) Other (please comment): _____

   (If have stopped using a breathing device then you have completed the form.)

   Otherwise Please Continue

2. I am still using the breathing device that was prescribed for me the last time I got a prescription.

3. What kind of breathing device(s) do you currently have? (mark all that apply)
   a) Bipap
   b) Nighttime ventilation (with tracheostomy)
   c) Full 24 hour ventilator
   d) Other (please specify): _____

4. When did you obtain your present breathing device(s)? Month_____ Day_____ Year _____

5. Was the initial decision to use Mechanical Ventilation made by you?

   Yes, If yes then go to Question 6, on next page.

   No, If no then go to Question 8, on next page.

Please Continue

6. How difficult was it for you to make the decision to use a breathing device? (mark between 1 and 5**)**

Not Difficult				**Extremely Difficult**
1	2	3	4	5

7. What factors influenced you to make the decision to choose the breathing device?

_____

_____

8. How difficult was it for you to make the decision to continue to use a breathing device? (mark between 1 and 5**)**

Not Difficult				**Extremely Difficult**
1	2	3	4	5

9. What factors influenced you to make the decision to continue to use the breathing device?

_____

_____

10.a. Has there been any change in the amount of time that you use your device since getting it?

i) No. I use it as much as I always have.
ii) Yes. I use it more than I did when I first got it.
iii) Yes. I use it less than I did when I first got it.
iv) Other (please specify):_____

10.b. If there has been a change, what is the reason for the change?

_____

_____

11. How would you rate your satisfaction with your present device? *(mark a number between 1 and 5)*

Not Satisfied				**Extremely Satisfied**
1	2	3	4	5

12. How much difficulty did you experience adjusting to your present device? *(mark a number between 1 and 5)*

Extreme Difficulty				**No Difficulty At All**
1	2	3	4	5

13. If you have any additional comments, please writing them in the space below.

_____

_____

_____

When you have completed this questionnaire, please return it to:

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