Appendix 1: Collection tool for telephone calls

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_

Name of patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who initiated call (name and relationship): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason for call (narrative as described by caller): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Motor Symptoms:

|  |  |
| --- | --- |
| Delayed on  | How long? |
| End of dose wearing off | Times? |
| Dyskinesias | When? How disturbing? |
| Dystonia (toe and muscle cramping) | Off or on state? |
| Falls 🡪 go through items below | Where and how? |
| 1. Loss of balance?
 |  |
| 1. Freezing of gait?
 | On or off? |
| 1. Pain? Weakness?
 | Where:How does it feel like? |
| 1. Do you use any gait aid? Use at all times, only outdoor, occasionally indoor?
 | walker, cane, wheelchair |
| 1. Dizziness/presyncope/syncope?
 |  |

Medication Factors:

|  |  |
| --- | --- |
| Recent medication changes |  |
| Medication adherence? |  |
| Medication 30 min before meals? |  |
| Adverse effects of medications? |  |
| Potential drug interactions? |  |
| Inappropriate drug use? |  |

Non-Motor Symptoms – Autonomic

|  |  |
| --- | --- |
| Dizziness or presyncope/syncope |  |
| Constipation – frequency and Bristol type |  |
| Dysphagia |  |
| Acid Reflux or upset stomach/bloating/burping |  |
| Loss of appetite or nausea |  |
| Weight loss | Quantity: |
| Unable to urinate or to hold urine |  |
| Frequent urination at night | If yes, how many times at night? |

Non-Motor Symptoms – Neuropsychiatric

|  |  |
| --- | --- |
| Cognitive decline? | Examples: |
| Visual hallucinations? | Describe: |
| Delusions | Examples: |
| Trouble falling asleep |  |
| Unable to sleep through the night | Reasons? |
| Shouting/kicking in sleep/falling out of bed (REM sleep behavior) |  |
| Restless legs |  |
| Depressed mood |  |
| Anxiety |  |
| Daytime sleepiness |  |
| Agitation/aggression |  |
| Impulsive behaviour |  |

Intention to visit ED: YES/NO

Intervention provided:

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

Call duration: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Follow up date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Outcome: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_