



Pleural Procedure Patient Survey

Clinical Details


Date of Procedure		
Date of Birth		
Sex	Male	<input type="checkbox"/>
	Female	<input type="checkbox"/>
Diagnosis	Malignant Pleural Effusion	<input type="checkbox"/>
	Infected Pleural Effusion	<input type="checkbox"/>
	Effusion not diagnosed	<input type="checkbox"/>
	Other (_____)	<input type="checkbox"/>
	Primary pneumothorax	<input type="checkbox"/>
	Secondary Pneumothorax	<input type="checkbox"/>
Procedure performed	Fluid	
	Diagnostic Aspiration	<input type="checkbox"/>
	Therapeutic Aspiration	<input type="checkbox"/>
	Intercostal Drain Insertion	<input type="checkbox"/>
	Indwelling Catheter Insertion	<input type="checkbox"/>
	Thoracoscopy	<input type="checkbox"/>
	Air	
	Aspiration	<input type="checkbox"/>
	Intercostal Drain Insertion	<input type="checkbox"/>
Has talc been given?	Yes (date _____)	<input type="checkbox"/>
	No	<input type="checkbox"/>
What (if any) local anaesthetic was used?	LA (e.g. lidocaine 1%):	Dose (mls):
% opacification on CXR (% of hemithorax occupied by pleural shadowing)	0-30%	<input type="checkbox"/>
	31-50%	<input type="checkbox"/>
	>50%	<input type="checkbox"/>
OR		
Size of pneumothorax	Small (<2cm apex or mid-axillary distance)	<input type="checkbox"/>
	Large (>2cm)	<input type="checkbox"/>
Volume of fluid drained	_____ mls	
Time over which fluid drained	_____ minutes	
	_____ hours	
Time after intervention at which patient symptoms recorded	_____ hours	




Participant Questions

1. The procedure:

How painful was the procedure?

Not painful at all  Worst possible pain

Would you have the procedure again if needed?

Definitely yes  Definitely no


What could be done to improve the procedure?

Nothing Less pain Shorter wait to have the procedure Better explanation of the procedure	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Other (please give details)	




2. Your symptoms:


How breathless have you felt on average in the last 24 hours before the procedure?

Not breathless at all  Worst possible breathlessness

What do you consider to be a change in your breathing that would be worth having this procedure again?

No change in breathlessness  Complete resolution of breathlessness

On average how breathless were you after the procedure?

Not breathless at all  Worst possible breathlessness

**How much change have you noticed in your breathing after the procedure?
Please tick 1 box.**

Large or moderately worse	<input type="checkbox"/>
Small but significantly worse	<input type="checkbox"/>
Slightly worse but not significant	<input type="checkbox"/>
No change	<input type="checkbox"/>
Slightly better but not worthwhile	<input type="checkbox"/>
Slightly better but worthwhile	<input type="checkbox"/>
Large or moderately better	<input type="checkbox"/>

Any comments?

Thank you for completing this questionnaire please hand back to your doctor.