# Patient Survey

**Introduction**

Thank you for taking the time to complete this evaluation on Curtin University’s *MedsCheck Plus* pilot service. You will remain anonymous. The survey does not contain any questions that enable us to identify you.

Your opinions and experiences are valuable to our research.

Please click the link to read the *Patient Information Statement*

**Participant Consent**

* I have read the information statement linked above and I understand its contents
* I believe I understand the purpose, extent and possible risks of my involvement in this project
* I voluntarily consent to take part in this research project
* I confirm that I as the patient, make my own medical decision and don’t require the assistance of another individual
* I have had an opportunity to ask questions and I am satisfied with the answers received
* I understand that this project has been approved by Curtin University Human Research Ethics Committee and will be carried out in line with the National Statement on Ethical Conduct in Human Research (2007)
* I understand I will receive a copy of this information statement and consent form.

**Patient Information**

What is your gender?

[ ]  Male

[ ]  Female

[ ]  Non-binary

[ ]  Other Click or tap here to enter text. (Prefer to self describe)

What is your age?

[ ]  18-24

[ ]  25-34

[ ]  35-44

[ ]  45-54

[ ]  55-64

[ ]  65-74

[ ]  75 or older

[ ]  I would prefer not to say

Do you identify as: (please select all that apply)

[ ]  Aboriginal and/or Torres Strait Islander

[ ]  Culturally and linguistically diverse

[ ]  Person with disabilities

[ ]  LGBTIQA+

[ ]  On a temporary visa

[ ]  None of the above

What is the postcode of your primary place of residence?

Click or tap here to enter text.

Do you live alone?

[ ]  Yes

[ ]  No

Do you have a carer to assist you with managing your medication?

[ ]  Yes

[ ]  No

**Please select the options that best describe how you were managing your medication BEFORE you received your *MedsCheck Plus* service: (select all that apply)**

[ ]  I was taking my medication correctly as prescribed by my doctor

[ ]  I have previously participated in a MedsCheck and have taken my medication correctly as prescribed by my pharmacist

[ ]  I sometimes became confused about when to take my medication or sometimes forgot to take my medication

[ ]  I was unsure if I was taking my medication correctly

**Did a family carer attend your *MedsCheck Plus* with you?**

[ ]  Yes

[ ]  No

**The following statements are designed to assess the quality of the service you received. Select the most appropriate option.**

***The information given to me/us by the pharmacist was useful***

[ ]  Strongly agree [ ]  Somewhat agree [ ]  Neither agree nor disagree [ ]  Somewhat disagree [ ]  Strongly disagree

***The report given to me/us by the pharmacist was useful***

[ ]  Strongly agree [ ]  Somewhat agree [ ]  Neither agree nor disagree [ ]  Somewhat disagree [ ]  Strongly disagree

***The pharmacist was knowledgeable in the area of dementia***

[ ]  Strongly agree [ ]  Somewhat agree [ ]  Neither agree nor disagree [ ]  Somewhat disagree [ ]  Strongly disagree

***I/we was comfortable with the environment in which the service was conducted***

[ ]  Strongly agree [ ]  Somewhat agree [ ]  Neither agree nor disagree [ ]  Somewhat disagree [ ]  Strongly disagree

***I/we was satisfied with the service***

[ ]  Strongly agree [ ]  Somewhat agree [ ]  Neither agree nor disagree [ ]  Somewhat disagree [ ]  Strongly disagree

***I/we would recommend this service to others***

[ ]  Strongly agree [ ]  Somewhat agree [ ]  Neither agree nor disagree [ ]  Somewhat disagree [ ]  Strongly disagree

**The following statements are designed to assess how you/your carer benefited from the service. We want to know if the service helped you/your carer understand and manage your medication better. Select the most appropriate option.**

***As a result of the service, I/we now have increased confidence in the way I/we manage my/patient medication (ie the dose, when to take the medication, how to take the medication)***

[ ]  Strongly agree [ ]  Somewhat agree [ ]  Neither agree nor disagree [ ]  Somewhat disagree [ ]  Strongly disagree

***As a result of the service, I/we have a better understanding of the conditions my medications treat***

[ ]  Strongly agree [ ]  Somewhat agree [ ]  Neither agree nor disagree [ ]  Somewhat disagree [ ]  Strongly disagree

***As a result of the service, I/we now have a better understanding of the side effects of my medication***

[ ]  Strongly agree [ ]  Somewhat agree [ ]  Neither agree nor disagree [ ]  Somewhat disagree [ ]  Strongly disagree

***As a result, I/we now have a better understanding about what medication and/or other health products and/or food I should avoid when taking my regular medication***

[ ]  Strongly agree [ ]  Somewhat agree [ ]  Neither agree nor disagree [ ]  Somewhat disagree [ ]  Strongly disagree

***As a result of the service, I/we now have a better understanding of how to store my medication:***

[ ]  Strongly agree [ ]  Somewhat agree [ ]  Neither agree nor disagree [ ]  Somewhat disagree [ ]  Strongly disagree

***Overall I/we feel I have benefited from the service:***

[ ]  Strongly agree [ ]  Somewhat agree [ ]  Neither agree nor disagree [ ]  Somewhat disagree [ ]  Strongly disagree

**We want to know if you have changed the way you manage your medicines as a result of receiving the service. Select the most appropriate option.**

***As a result of the service, have you/your carer made changes to the way you/your carer manage your medication? (Examples of changes include using a dosette box or dose administration aid for your tablets, using a spacer with your puffer, changing the way you use your puffers, or changing the place you use to store your medicines etc.***

[ ]  I/we have not made any changes. The pharmacist was happy with the way I manage my medicines.

[ ]  I/we have not made the changes recommended by the pharmacist as I did not think they would help me.

[ ]  I/we have not made the changes recommended by the pharmacist as yet, but I intend to in the future.

[ ]  I/we have made the changes recommended by the pharmacist.

***As a result of the service, have you returned to your GP to discuss the action plan made by your pharmacist?***

[ ]  I/we have not visited my/patient’s GP. The pharmacist did not recommend this.

[ ]  I/we have not visited my/patient’s GP since the service as I did not think this would be useful

[ ]  I/we have not visited my/patient’s GP to discuss the action plan, but I intend to in the future

[ ]  I/we have visited my GP to discuss my/patient’s action plan

***As a result of the service, have you approached another health care provider other than your GP for assistance? (Examples of other health providers include a dietician, an exercise physiologist, a physiotherapist, etc).***

[ ]  I/we have not approached another health care provider. The pharmacist did not recommend this.

[ ]  I/we have not approached another health care provider as recommended by the pharmacist as I did not think this would be useful.

[ ]  I/we have not approached another health care provider as recommended by the pharmacist as yet, but I intend to in the future.

[ ]  I/we have approached another health care provider as recommended by the pharmacist.

***As a result of the service, have you approached a support service recommended by the pharmacist? (ie Dementia Australia, Alzheimer’s WA)***

[ ]  I/we have not approached a support service. The pharmacist did not recommend this.

[ ]  I/we have not approached a support service as recommended by the pharmacist as I/we did not think this would be useful.

[ ]  I/we have not approached a support service as recommended by the pharmacist as yet, but I/we intend to in the future.

[ ]  I/we have approached a support service as recommended by the pharmacist.

***Did the pharmacist recommend you have a home medicines review?***

[ ]  Yes

[ ]  No

[ ]  Unsure

**THANK YOU FOR COMPLETING THE SURVEY. PLEASE POST IT BACK USING THE REPLY PAID ENVELOPE**