Patient expectations questionnaire regarding treatment outcomes in spinal oncology

Surgery

Patient Name: _____

Date (MM/DD/YY): _____ / _____ / _____

Patient ID: _____
(to be filled in by the health professional)

A) Patient expectations of treatment outcomes

The following questions are about your expectations on how surgery will have an effect on the symptoms caused by your spine tumor. Please first indicate **what** you **expect (not hope)**, followed by **when** you **expect (not hope)** this change after surgery (i.e., in the first 2 weeks, between 2–6 weeks or more than 6 weeks after surgery). There are no right or wrong answers.

Compared to your symptoms one week ago, what do you anticipate surgery will do for the following?

		Much worse	Somewhat worse	No change	Somewhat better	Much better	Do not know	Not applicable	<2 weeks	2–6 weeks	>6 weeks	Do not know
1.	**The pain in your back/neck?**	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
2.	**Fatigue?**	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
3.	**The strength in your arms?**	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
4.	**The strength in your legs?**	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
5.	**Your ability to do 15 minutes of mild to moderate physical activities? (e.g. walk, bicycle ride)**	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
6.	**Your ability to drive yourself?**	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
7.	**Your ability to care for yourself? (e.g. bathing, showering, dressing)**	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
8.	**Your ability to independently perform moderate daily activities? (e.g. vacuuming, window cleaning, carrying groceries)**	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
9.	**Your ability to engage in social activities with family/ friends/groups outside your house?**	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
10.	**Bladder problems? (e.g. incontinence, retention)**	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
11.	**Bowel problems? (e.g. incontinence, constipation)**	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
12	**Your overall quality of life?**	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

		No pain medication	Less pain medication	No change	More pain medication	Much more pain medication	Do not know	Not applicable	<2 weeks	2–6 weeks	>6 weeks	Do not know
13.	**The amount of pain medication that you take?**	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

B) Prognosis

The following statements are about how you feel about your prognosis. Please indicate which options best describe your answer. There are no right or wrong answers.

14. I expect that surgery will have the following outcomes (more than one answer possible):

- ☐ Reduce my pain
- ☐ Improve my quality of life
- ☐ Improve my mobility
- ☐ Remove my tumor in my spine
- ☐ Improve my chance of cure
- ☐ Improve my life expectancy

15. I have had a discussion with my healthcare provider (e.g. spine surgeon, radiation oncologist, medical oncologist, nurse practitioner) about my life expectancy.

- ☐ No (please select which applies)
  - ☐ Not discussed by my physician
  - ☐ I prefer not to discuss my life expectancy
- ☐ Yes (select all that apply)
  - ☐ Medical oncologist
  - ☐ Radiation oncologist
  - ☐ Spine surgeon
  - ☐ Other: _____

16. What do you feel are the chances that your cancer can be cured with surgery for your spine?

- ☐ Not curable
- ☐ Less than 50 % chance of cure
- ☐ 50 % chance of cure
- ☐ More than 50 % chance of cure
- ☐ Do not know
- ☐ Prefer not to answer

C) Consultation with my spine surgeon

The following statements are about your consultation with your spine surgeon about the tumor in your spine. Please indicate to what extent you agree or disagree with these statements.

		Strongly disagree	Disagree	Undecided	Agree	Strongly agree
17.	**I feel that I understand the information provided by my spine surgeon.**	☐	☐	☐	☐	☐
18.	**I feel that I understand the reasons for my spine surgery.**	☐	☐	☐	☐	☐
19.	**I feel that I understand the benefits of spine surgery.**	☐	☐	☐	☐	☐
20.	**I feel that I understand the risks of surgery.**	☐	☐	☐	☐	☐
21.	**I feel that I understand the expected functional outcomes (e.g. pain management, ability for self-care, mobility) after spine surgery.**	☐	☐	☐	☐	☐
22.	**I feel that the physician involved me in the decision for my treatment.**	☐	☐	☐	☐	☐

Form modified November, 2022