

## Part C: Anonymous patient information

### Section 1 – Selecting your \_\_\_\_ patient (1<sup>st</sup> – 4<sup>th</sup>)

The data you are entering in this section is not linked to your identity and is registered separately from the data you entered in Part B.

Using the date which will be provided to you below, look in your work calendar and identify the first patient you saw in the following 24-hours. The patient must be a new patient, or an existing patient with a new episode (i.e. returning with a new complaint or with a recurrent complaint, but symptom-free for at least six weeks since their previous appointment).

**Please get a random date and time by scanning the QR-code with your smartphone. If you do not have a QR-reader installed, just go to your AppStore and download a free QR-code reader. Alternatively, you can enter the address in to your browser.**



[bit.ly/2n5Fcub](http://bit.ly/2n5Fcub)

**C1\_1 Did you see a new patient or a returning patient with a new episode in the 24-hours following the given date and time?**

- Yes (go to C2)
- No

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Please refresh the page to be provided with a new date.

**C1\_2 Did you see a new patient or a returning patient with a new episode in the 24-hours following the given date and time?**

- Yes (go to C2)
  - No
-

Please refresh the page to be provided with a new date.

**C1\_3 Did you see a new patient or a returning patient with a new episode in the 24-hours following the given date and time?**

- Yes (go to C2)
- No

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Please refresh the page to be provided with a new date.

**C1\_4 Did you see a new patient or a returning patient with a new episode in the 24-hours following the given date and time?**

- Yes (go to C2)
- No

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Please refresh the page to be provided with a new date.

**C1\_5 Did you see a new patient or a returning patient with a new episode in the 24-hours following the given date and time?**

- Yes (go to C2)
- No

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Please refresh the page to be provided with a new date.

**C1\_6 Did you see a new patient or a returning patient with a new episode in the 24-hours following the given date and time?**

- Yes (go to C2)
  - No
-

Please refresh the page to be provided with a new date.

**C1\_7 Did you see a new patient or a returning patient with a new episode in the 24-hours following the given date and time?**

- Yes (go to C2)
- No

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Please refresh the page to be provided with a new date.

**C1\_8 Did you see a new patient or a returning patient with a new episode in the 24-hours following the given date and time?**

- Yes (go to C2)
- No

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Please refresh the page to be provided with a new date.

**C1\_9 Did you see a new patient or a returning patient with a new episode in the 24-hours following the given date and time?**

- Yes (go to C2)
- No

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Please refresh the page to be provided with a new date.

**C1\_10 Did you see a new patient or a returning patient with a new episode in the 24-hours following the given date and time?**

- Yes (go to C2)
  - No
-

Please refresh the page to be provided with a new date.

**C1\_11 Did you see a new patient or a returning patient with a new episode in the 24-hours following the given date and time?**

- Yes (go to C2)
- No

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Please refresh the page to be provided with a new date.

**C1\_12 Did you see a new patient or a returning patient with a new episode in the 24-hours following the given date and time?**

- Yes (go to C2)
- No

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*It seems like you are having difficulties finding a timeframe where you saw a patient.*

*Please contact Paul Vaucher by writing an email to [paul.vaucher@hes-so.ch](mailto:paul.vaucher@hes-so.ch) to be provided with a customised timeframe that suits you better.*

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**C2 In which month did this patient appointment take place?**

\_\_\_\_\_

**C3 On which day of the week did this patient appointment take place?**

\_\_\_\_\_

**C4 At what time did the patient appointment start?**

- Before 8 AM
- Between 8 AM and 9:59 AM
- Between 10 AM and 3:59 PM
- Between 4 PM and 5:59 PM
- 6 PM or later

(continue with Section 2 – General patient information)

## Section 2 – General patient information

We recommend you to make a note in the patient's record, that you have used this patient's record for the SwissOsteoSurvey. This will allow you to inform the patient, should they ask you in the future.

Please answer the following questions based on the information in your patient's records.

**C5 Patient sex**

(if sex is ambiguous, refer to the sex the patient identifies to)

- Male  Female

**C6 Is your patient above 2 years of age?**

- Yes (go to C6b)  
 No (go to C6c)

**C6b Patient age in years: --**  
(go to C7)

**C6c Patient age in months: --**

**C7 Residential region:**

- Lake Geneva Region (GE, VD, VS)  
 Espace midlands (BE, FR, JU, NE, SO)  
 Northwestern Switzerland and Zurich (AG, BS, BL, ZH)  
 Eastern Switzerland (AI, AR, GL, SG, SH, TG)  
 Central Switzerland (LU, NW, OW, SZ, UR, ZG)  
 Graubünden and Ticino (GR, TI)

**C8 How would you describe the patient's current work status?**

(tick all applicable boxes)

- Pupil/student
  - Pre-school
  - Primary school
  - Secondary school
  - Tertiary education/higher education/university
- Self-employed
  - At what percentage? (42h/w = 100%): \_\_\_\_\_
  - Don't know/can't tell from the records
- Employed
  - At what percentage? (42h/w = 100%): \_\_\_\_\_
  - Don't know/can't tell from the records
- Housewife/househusband
- Not currently working/studying
  - Unemployed for health reasons
  - Retired
  - Infant/child
  - Other (please specify): \_\_\_\_\_
- Don't know/can't tell from the records

**C9 Has the patient ever had any osteopathic treatment before?**

(tick all applicable boxes)

- Yes, with me for a previous episode of the same complaint
- Yes, with me for a different complaint
- Yes, with another osteopath
- No
- Don't know/can't tell from the records

**C10 Was the patient referred to you by someone?**

- Yes
- No (go to C11)
- Don't know/can't tell from the records (go to C11)

**C10b Who referred the patient to you?**

- General practitioner
- Dentist
- Pharmacist
- Chiropractor
- Another medical specialist, please specify \_\_\_\_\_
- Another osteopath  
(including an assistant)
- Midwife
- Physiotherapist
- Occupational therapist
- Nutritionist
- Nurse practitioner
- Another allied health professional, please specify \_\_\_\_\_
- Complementary therapist

**C11 How long did the patient have to wait to see you?**

- 1 Day or less
- 2–3 days
- 4–7 days
- 8 days or more
- Don't know/can't tell from the records

## Section 3 – Information about the patient’s complaint at the first appointment

**C12** How would you describe the main presenting complaint?

(tick all applicable boxes)

- Musculoskeletal pain or dysfunction
- Infancy-related complaints
- Dentistry/orthodontics
- Ear-nose-throat
- Neurological
- Rheumatological
- Gastrointestinal
- Obstetrical
- Gynaecological
- Psychological
- Endocrinological
- Respiratory
- Cardiovascular
- Urogenital
- Dermatological
- Ophthalmological
- General/non-specific
- Prevention
- Other (please specify): \_\_\_\_\_



**C13 For how long has the patient had this problem for, including prior episodes?**

- 24h or less
- 1–2 days
- 2–7 days
- 1–4 weeks
- 1–6 months
- 6–12 months
- 1–2 years
- 2–5 years
- 5–10 years
- More than 10 years
- Don't know/can't tell from the records

**C14 Before this first appointment, how long had the patient been off work/school with this problem?**

- Hasn't been off work/school
- 24h or less
- 1–2 days
- 2–7 days
- 1–4 weeks
- 1–6 months
- 6–24 months
- More than 24 months
- Don't know/can't tell from the records

**C15 Has the patient had previous treatment or undergone investigations for this episode?**

- Yes
- No (go to C16)
- Don't know/can't tell from the records (go to C16)

**C15b Who had the patient previously seen for this episode?**

(tick all applicable boxes)

- General practitioner
- Pharmacist
- Physiotherapist
- Other osteopath
- Other assistant osteopath
- Complementary therapist
- Medical specialist (please specify): \_\_\_\_\_
- Other (please specify): \_\_\_\_\_

**C15c What type of investigations had already been performed for this condition and have you seen the report or the actual exam results?**

(tick all applicable boxes)

	Done	Seen	
		Report	Exam Results
X-ray	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
CT scan	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
MRI	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other types of imaging	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blood test	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Urine analysis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (please specify): _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**C15d What type of treatments had the patient already received for this episode?**

(tick all applicable boxes)

- Self-medication
- Prescribed medication
- Manual therapy
- Surgery
- Complementary medicine
- Other (please specify): \_\_\_\_\_

**C16 Please describe the onset of symptoms:**

- Traumatic onset
- Acute/sudden onset (non traumatic)
- Slow/insidious onset
- Don't know/can't tell from the records

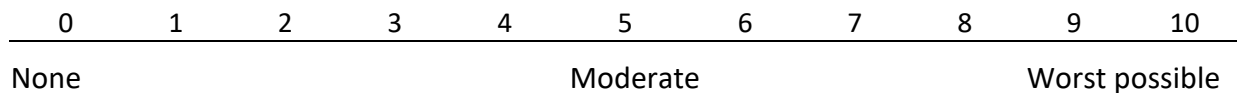
**C17 Which episode of symptoms was it?**

- First episode
- Second episode
- Third episode
- Fourth or more episodes
- Don't know/can't tell from the records

**C18 Did you record the severity of the main symptoms at the first appointment?**

- Yes
- No (go to C18c)

**C18b Please indicate the recorded severity:**



(go to C19)

**C18c Please estimate the severity of main symptoms:**

- None
- Mild
- Moderate
- Severe
- Worst imaginable
- Don't know/can't tell from the records

**C19** Please enter up to four predominate symptom areas in order of priority for the given patient:

Area	1 <sup>st</sup>	2 <sup>nd</sup>	3 <sup>rd</sup>	4 <sup>th</sup>
Head/facial area	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Temporo-mandibular	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Neck	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Shoulder	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Upper-arm	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Elbow	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Forearm	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Wrist	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Hand	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Thoracic spine	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Thoracic cage	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Lumbar	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sacroiliac/pelvis/groin	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Gluteal region	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Hip	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Thigh/upper leg	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Knee	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Lower leg	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Ankle	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Foot	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Abdomen	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Other	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**C20** What current co-existing conditions, diagnosed by a medical practitioner, does the patient have?

(tick all applicable boxes)

- Don't know/can't tell from the records
- None

*Cardiovascular diseases (CVD)*

- Hypertension
- Angina
- CHF (congestive heart failure)
- MI (myocardial infarct)
- Stroke/TIA (transient ischaemic attack)
- Peripheral vascular disease
- Other CVD disease

*Mental disorders*

- Anxiety
- Depression
- Dementia
- Other mental disorder

*Rheumatological disorders*

- Arthritis
- Osteoporosis
- Other rheumatological disorder

*Sensorial and neurological disorders*

- Migraine
- Hearing impairment
- Visual impairment
- Neurological disease
- Other neurological disorder

*Respiratory disorders*

- Asthma
- COPD (chronic obstructive pulmonary disease)
- Other respiratory disorder

*Kidney/liver disorders*

- Kidney disease
- Liver disease
- Other kidney/liver diseases

*Digestive disorders*

- Upper gastrointestinal disease
- Chronic inflammatory disease (Crohn's disease / ulcerative colitis)
- Irritable bowel syndrome (IBS)
- Other diagnosed digestive disorders

*General disorders/conditions*

- Pregnancy
- Anaemia
- Diabetes
- Cancer
- Other general disorder condition

*Other (please specify):* \_\_\_\_\_

## Section 4 – Treatment and Management

### **C21 Which of the following examination procedures did you use during the first visit?**

(tick all applicable boxes)

- Don't know/can't tell from the records (go to C22)
- None (go to C22)
- Observation
- Palpation of position/structures
- Palpation of tenderness
- Joint range of motion
- Palpation of joint movement quality
- Visceral mobility
- Cranial mobility
- Fascial testing
- Neurolymphatic reflex tests (eg. Chapman and Jarricot Reflex)
- Nerve stretch tests
- Muscle function
- Orthopaedic tests
- Percussion and auscultation
- Neurological examination
- Patient questionnaires (e.g. Oswestry Disability Index)
- Otoscopy (ear/nose/throat)
- Ophthalmoscopy (eyes)
- Diagnostic imaging (e.g. X-ray, MRI)
- Blood analysis
- Urine analysis
- Other (please specify): \_\_\_\_\_

**C21b How was consent gained for examination?**

(please note that you cannot be identified from the responses you give)

- Implied consent
- Verbal
- Written
- Written and verbal
- Other (please specify): \_\_\_\_\_
- Don't know/can't tell from the records
- No consent taken

**C22 What treatment plan was agreed with the patient?**

(tick all applicable boxes)

- Osteopathic management
- Single consultation only
- Patient was referred on
- No treatment plan agreement
- Don't know/can't tell from the records

**C23 What types of treatment approaches were used with the patient?**

(tick all applicable boxes)

- Don't know/can't tell from the records (go to C24)
- None (go to C24)
- Soft tissue techniques
- Articulatory techniques
- HVLA thrust
- Cranial techniques
- Muscle energy
- Strain/counterstrain
- Functional technique
- General osteopathic treatment (GOT)
- Visceral
- Myofascial release (MFR)
- Inhibition techniques (e.g. trigger points)
- Biodynamic approach
- No hands-on treatment



- Exercise – strengthening
- Exercise – stretching
- Exercise – proprioception
- Exercise – mindfulness
- Relaxation
- Self-management
- Lifestyle advice
- Pain neuroscience education (PNE)
- Dietary advice
- Self-medication advice
- Nutrition therapy
- Orthotics
- Psychological treatment
- Hypnosis
- Acupuncture
- Dry needling
- Homeopathy
- Herbal medicine
- Applied or clinical kinesiology
- Bio-resonance therapy
- Electro-therapy
- Prescription of medication
- Injections
- Other (please specify): \_\_\_\_\_

**C23b How was consent gained for treatment?**

(please note that you cannot be identified from the responses you give)

- Implied consent
- Verbal
- Written
- Written and verbal
- Other (please specify): \_\_\_\_\_
- Don't know/can't tell from the records
- No consent

**C24 Were any of the following procedures conducted and were you able to obtain specific consent?**

(specific consent is only valid if patients were explicitly given the option to refuse the proposed procedure)

Procedure	Conducted		Specific consent	
	Yes	No	Yes	No
Rectal	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Vaginal	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Oral	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
In-ear	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Cervical HVT	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Thoracic HVT	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Lumbar HVT	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**C25 Did you discuss any of the following with the patient?**

	Yes	No	Can't tell
Treatment options for the presenting complaint	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Possible risks and side effects of treatment	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Anticipated response to treatment	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Anticipated number of treatments	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Ways to avoid recurrences in the future	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
An explanation of the presenting complaint	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**C26 What self-management strategies, if any, did you recommend to the patient?**

(tick all applicable boxes)

- Don't know/can't tell from the records
- None
- Application of heat
- Application of cold
- Contrast bathing
- RICE protocol (rest ice compression elevation)
- Rest

- Strengthening exercise
- Stretching exercise
- Proprioceptive exercise
- Mindfulness exercise
- General physical activity
- Relaxation advice
- Advice concerning physical activity
- Vitamins or other nutritional supplements
- Natural remedies
- Naturopathic neuromuscular techniques (kinesiology)
- Other (please specify): \_\_\_\_\_

**C27 Who paid for most of the treatment?**

- The patient
- Patient's private insurance company
- Employer's accident insurance company
- Private accident insurance company
- Invalidity insurance
- Patient's employer
- Other (please specify): \_\_\_\_\_
- Don't know/can't tell from the records

**C28 Is an insurance case or litigation claim pending in relation to the presenting complaint?**

- Yes
- No
- Don't know/can't tell from the records

**C29 How much time did you spend on this first appointment?**

- Don't know/can't tell from the records (go to C30)

\_\_\_\_\_ minutes

**C29b What proportion of this time did you (approximately) spend on the following?**

(Enter "999" if you don't know/can't tell from the records)

Case history	__ min
Examination	__ min
Discussion of treatment	__ min
Discussion of consent	__ min
Treatment	__ min
Advice and guidance (including psychological support)	__ min
Administration	__ min
Other (please specify:_____)	__ min

**C30 Did the patient return for a second appointment?**

- Yes (go to C31)
- No

**C30b Why not?**

(tick all applicable boxes)

- The patient was referred to another health care practitioner
- The patient was discharged
- The patient declined to book another appointment
- The patient didn't attend the scheduled appointment
- The patient cancelled the appointment
- Don't know/can't tell from the records

(go to C43)

## Section 5 – The second appointment

**C31 Did the patient report any complications as a result of the first treatment?**

(tick all applicable boxes)

- No
- Don't know/can't tell from the records
- Increased pain
- Increased stiffness
- Dizziness
- Nausea
- Headache
- Fatigue
- Serious adverse event  
(If known, please give details): \_\_\_\_\_
- Other (please specify): \_\_\_\_\_

**C32 What was the patient's overall outcome after the first appointment?**

- Worst ever
- Much worse
- Worse
- No change
- Improved
- Much improved
- Best ever
- Don't know/can't tell from the records

**C33 What types of treatment approaches were used with the patient at the second appointment?**

(tick all applicable boxes)

- Don't know/can't tell from the records (go to C34)
- None (go to C34)
- Soft tissue techniques
- Articulatory techniques
- HVLA thrust
- Cranial techniques

- Muscle energy
- Strain/counterstrain
- Functional technique
- General osteopathic treatment (GOT)
- Visceral
- Myofascial release (MFR)
- Inhibition techniques (e.g. trigger points)
- Biodynamic approach
- No hands-on treatment
- Exercise – strengthening
- Exercise – stretching
- Exercise – proprioception
- Exercise – mindfulness
- Relaxation
- Self-management
- Lifestyle advice
- Pain neuroscience education (PNE)
- Dietary advice
- Self-medication advice
- Nutrition therapy
- Orthotics
- Psychological treatment
- Hypnosis
- Acupuncture
- Dry needling
- Homeopathy
- Herbal medicine
- Applied or clinical kinesiology
- Bio-resonance therapy
- Electro-therapy
- Prescription of medication
- Injections
- Other (please name): \_\_\_\_\_

**C34 What self-management strategies, if any, did you recommend to the patient?**

(tick all applicable boxes)

- Don't know/can't tell from the records
- None
- Application of heat
- Application of cold
- Contrast bathing
- RICE protocol (rest ice compression elevation)
- Rest
- Strengthening exercise
- Stretching exercise
- Proprioceptive exercise
- Mindfulness exercise
- General physical activity
- Relaxation advice
- Advice concerning physical activity
- Vitamins or other nutritional supplements
- Natural remedies
- Naturopathic neuromuscular techniques (kinesiology)
- Other (please state) \_\_\_\_\_

**C35 Please enter the time spent for the second appointment:**

- Don't know/can't tell from the records (go to C36)

\_\_\_\_\_ *minutes*

**C36 Did the patient return for a third appointment?**

- Yes (go to C37)
- No (go to C40)

## Section 6 – Last appointment of initial course of treatment for this episode

**C37** Please enter the total number of treatments for this episode  
(up to and including the most recent appointment)

- Don't know/can't tell from the records (go to C40)

Amount: \_\_

**C38** Is the patient continuing to report any complications as a result of the treatment?  
(tick all applicable boxes)

- No
- Don't know/can't tell from the records
- Increased pain
- Increased stiffness
- Dizziness
- Nausea
- Headache
- Fatigue
- Serious adverse event (If known, please give details): \_\_\_\_\_
- Other (please specify): \_\_\_\_\_

**C39** What was the patient's overall outcome at their most recent appointment?

- Worst ever
- Much worse
- Worse
- No change
- Improved
- Much improved
- Best ever
- Don't know/can't tell from the records



**C40 Duration of treatment period for this episode:**

(first to most recent appointment)

*Use most relevant scale*

Weeks \_\_ Months \_\_

**C41 Has the patient completed the initial course of treatment for this episode?**

- Yes
- No, treatment is ongoing
- Patient did not return (reason unknown)
- Treatment terminated due to illness
- Treatment terminated for financial reasons
- Treatment terminated for other reasons (please specify): \_\_\_\_\_

**C42 Did you record the severity of the main symptoms at the last appointment?**

- Yes
- No (go to C42c)

**C42b Please indicate the recorded severity:**

0    1    2    3    4    5    6    7    8    9    10

---

None

Moderate

Worst possible

(go to C43)

**C42c Please estimate the severity of the main symptoms at the last appointment**

- None
- Mild
- Moderate
- Severe
- Worst imaginable
- Don't know/can't tell from the records

**C43 Were the set treatment goals achieved?**

- Don't know/can't tell from the records

<b>Not at all</b>	<b>Somewhat</b>	<b>Mostly</b>	<b>Totally</b>	<b>N/A</b>
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**C44 Did the patient take time off work/school since the first appointment, due to the episode under treatment?**

- Yes
- No (go to C45)
- Don't know/can't tell from the records (go to C45)

**C44b Was the patient able to return to work/school?**

- Yes
- No (go to C45)
- Don't know/can't tell from the records (go to C45)

**C44c How long after the appointment was the patient able to return to work/school?**

- Same day
- Following day
- 2–7 days
- 1–4 weeks
- 1–6 months
- 6–12 months
- More than 12 months
- Don't know/can't tell from the records

**C45 Did you contact the patient's general practitioner during this course of treatment?**

- Yes
- No (go to C46)
- Don't know/can't tell from the records (go to C46)

**C45b Why did you contact the patient's general practitioner?**

(tick all applicable boxes)

- Patient was referred by the general practitioner
- To request further information or investigations
- General practitioner had requested information
- To discuss referral for other treatment
- Other (please specify): \_\_\_\_\_
- Don't know/can't tell from the records

**C46 What future course of care was agreed upon at the last appointment?**

- Don't know/can't tell from the records
- None planned
- Patient was discharged
- Patient opted to return for episodic care
- Patient awaiting results of investigations
- Patient was referred on for investigations/treatment
- Still continuing initial course of treatment
- Patient planning to return for further treatment if necessary
- Other (please specify): \_\_\_\_\_

**C47 Since the first appointment, was the patient seen by anyone else for the main condition they have seen you for?**

- Yes
- No (go to the end of this section)
- Don't know/can't tell from the records (go to the end of this section)

**C47b Who were they seen by?**

(tick all applicable boxes)

- Accident and emergency ward
- Their general practitioner
- Other osteopath
- Dentist/orthodontist
- Other medical consultant (please specify): \_\_\_\_\_
- Complementary therapist (please specify): \_\_\_\_\_
- Psychologist
- Other healthcare provider (please specify): \_\_\_\_\_
- Don't know/can't tell from the records

**C47c Please specify to whom you referred the patient to:**

(tick all applicable boxes)

- I didn't refer the patient
- Accident and emergency ward
- Their general practitioner
- Other osteopath
- Dentist/orthodontist
- Other medical consultant (please specify): \_\_\_\_\_
- Complementary therapist (please specify): \_\_\_\_\_
- Psychologist
- Other healthcare provider (please specify): \_\_\_\_\_
- Don't know/can't tell from the records

## Completion of data entry

Thank you for entering your patient's data. If you have any questions, or problems, copying the data into the system, please contact Roy Macdonald during normal office hours on Wednesday, on Thursday afternoons or on Friday mornings at +41 (0)26 429 6113 or at [roy.macdonald@hefr.ch](mailto:roy.macdonald@hefr.ch).

**END OF SURVEY QUESTIONNAIRE**