



Name	PHN	Date (yyyy / mm / dd)
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1. For each category, please check the **one** response that best describes your abilities over the **past week**.

Dressing and Grooming	NO DIFFICULTY	SOME DIFFICULTY	MUCH DIFFICULTY	UNABLE TO DO
Dress yourself, including tying shoelaces and doing buttons	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shampoo your hair	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Rising	NO DIFFICULTY	SOME DIFFICULTY	MUCH DIFFICULTY	UNABLE TO DO
Stand up from an armless chair	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Get in and out of bed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Eating	NO DIFFICULTY	SOME DIFFICULTY	MUCH DIFFICULTY	UNABLE TO DO
Cut your meat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lift a full cup or glass to your mouth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Open a new carton of milk	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Walking	NO DIFFICULTY	SOME DIFFICULTY	MUCH DIFFICULTY	UNABLE TO DO
Walk outdoors on flat ground	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Climb up five stairs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Hygiene	NO DIFFICULTY	SOME DIFFICULTY	MUCH DIFFICULTY	UNABLE TO DO
Wash and dry your entire body	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Take a bath	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Get on and off the toilet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Reach	NO DIFFICULTY	SOME DIFFICULTY	MUCH DIFFICULTY	UNABLE TO DO
Reach and get down a 5 lb object (for example, a bag of sugar from just above your head)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bend down to pick up clothing from the floor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Grip	NO DIFFICULTY	SOME DIFFICULTY	MUCH DIFFICULTY	UNABLE TO DO
Open car doors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Open jars which have been previously opened	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Turn taps on and off	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Activities	NO DIFFICULTY	SOME DIFFICULTY	MUCH DIFFICULTY	UNABLE TO DO
Run errands and shop	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Get in and out of a car	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do chores such as vacuuming, housework or light gardening	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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2. Do you **usually** (more than 50% of the time) use the following aids or devices for any of the activities listed on page 1? *Check all that apply.*

- Canes
- Walker
- Crutches
- Wheelchair/scooter
- Raised toilet seat
- Bath seat
- Jar opener (for jars previously opened)
- Special or built-up utensils
- Special or built-up chair
- Bath rail
- Long-handled appliance for reach
- Other (specify) _____

3. Do you **usually** (more than 50% of the time) need help from another person for any of the following? *Check all that apply.*

- Errands and housework
- Reaching
- Dressing and grooming
- Gripping and opening things
- Eating
- Walking
- Rising
- Hygiene

4. Please circle the number, from 0 to 10, which indicates how much pain you have had in the **past week because of your arthritis**, with 0 being "no pain" and 10 being "pain as bad as it could be".

PAIN SCALE RATING: 0 1 2 3 4 5 6 7 8 9 10

PATIENT CONSENT

Personal information on this form is collected under the authority of, and in accordance with, the British Columbia *Pharmaceutical Services Act* and *Freedom of Information and Protection of Privacy Act*. It will not be disclosed to any persons without the patient's consent. The information you provide will be relevant to and used solely to (a) provide PharmaCare benefits for the medication requested, (b) to implement, monitor and evaluate this and other Ministry programs, and (c) to manage and plan for the health system generally. If you have any questions about the collection or use of this information, call Health Insurance BC from Vancouver at 1-604-683-7151 or from elsewhere in BC toll free at 1-800-663-7100 and ask to consult a pharmacist concerning the Special Authority process.

I authorize the prescriber to release to PharmaCare and in the Ministry of Health the information contained in this form and any other related information in the prescriber's custody as required for adjudication, monitoring and evaluation.

Patient's Signature

Date