Dear _____,

Thank you for choosing _____ for your care. We are interested in how you have been feeling since your surgery on _____ particularly during the 30 days after your surgery. Dr. _____ and the Department of Surgery at our hospital are members of the Michigan Surgical Quality Collaborative and we are gathering information on the outcomes of our patients after surgery to help us provide the best surgical care possible.

Participating is voluntary but we hope that you will take a few minutes to answer the questions below and on the back of this page. Your health is very important to us, so if you could please return the letter as soon as you are able, we will greatly appreciate your response. All of your answers will be kept strictly confidential.

1. Your email address*: _____Today's date: _____
   *Please know that your email address will only be used to follow up with you again and it will not be shared.

2. Have you been seen by a doctor or nurse (any type, not just your surgeon) for any reason since your surgery? **Yes No**

3. Did you have a follow up visit with your surgeon? **Yes No** If Yes, Date(s) of visit: _____

4. Name of doctor(s) you saw after surgery: _____

5. Did you go to an Emergency Department (ED), an urgent care clinic, or any hospital after your surgery? **Yes No**
   If Yes, which hospital/ED did you go to and why? _____
   Date(s) of ED visit, urgent care visit, or hospitalization: _____

6. Did you have any other surgery in the 30 days since your surgery? **Yes No**
   If Yes, what type of surgery did you have? _____ Date(s) of surgery: _____

7. Were you admitted to the hospital after any of these visits? **Yes No**
   If Yes, please explain why you were in the hospital: _____

8. Have you been treated for any of the following medical problems since your surgery? **Yes No**

□ Urinary Tract Infection Date:	□ Heart Attack Date:	□ Incision Infection Date: Description:
□ Blood Clot Date:	□ Pneumonia Date:	□ Other (example: Stroke, Sepsis) Date: Description:

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Only you can tell us how much better you feel or how your activity has changed since your surgery.
For the following questions, please circle or fill out your answer.

1. **Overall, how would you rate your satisfaction with your experience following your surgery?**

1	2	3	4	5	6	7	8	9	10
Extremely Dissatisfied									Extremely Satisfied

2. **In general, what would you say your quality of life is:**

1	2	3	4	5
Worst Possible				Best Possible

3. **Do you regret your decision to undergo surgery?**

1	2	3	4	5
Strongly Regret				Absolutely No Regret

4. **Thinking back, how would you rate your pain in the <u>first week after your surgery</u>?**

No Pain Moderate Pain
Minimal Pain Severe Pain

5. **Surgical site pain: Please rate your pain at the <u>site of your surgery</u> by circling the number that best describes your pain on <u>average</u> over the <u>last week</u>.**

0	1	2	3	4	5	6	7	8	9	10
No Pain										Worst Pain Imaginable

6. **Overall body pain: Please rate your <u>overall body pain</u> by circling the number that best describes your pain on <u>average</u> over the <u>last week.</u>**

0	1	2	3	4	5	6	7	8	9	10
No Pain										Worst Pain Imaginable

7. **How well do you feel that you have recovered from your surgery?** (*Please answer using a percentage from 0-100%)* _____

8. **Have you returned to all of your normal daily activities yet?** NO (if NO *you can skip question #9)* YES

9. **How many weeks did it take, after your surgery, for you to return to all of your normal daily activities?**_____

The following questions ask about opioid medications that you may have taken before your surgery or you were prescribed by a doctor after your surgery.

10. **Did you take any opioid pain medication at any time in the year <u>before</u> your surgery?** NO YES

11. **Did you get a prescription for opioid pain medication when you left the hospital <u>after</u> your surgery? This could be in the form of pills, liquid, or a patch.**
    NO *(you do not need to complete the rest of the survey)*
    YES *(please complete questions 11 – 18)*

12. **What was the name of the opioid pain medication(s) that you were prescribed?** (*Circle from the list below. This information can be found on the pill bottle label)*
    - Hydrocodone (Norco, Vicodin, Lortab, Lorcet)
    - Oxycodone (OxyContin, Percocet, Roxicodone)
    - Codeine (Tylenol 3 or 4)
    - Tramadol (Ultram, Ultram ER)
    - Other (Fentanyl, Morphine, Hydromorphone, Dilaudid, Methadone, or others)
    - Other: _____

13. **What was the dose you were prescribed?** (*example 5 mg*) _____

14. **What was the total number of pills, or total amount of liquid prescribed?** _____

15. **Did you fill the prescription at the pharmacy?** NO (if NO *you can stop here)* YES

16. **What is the total number of pills (or amount of liquid) that you have taken since your surgery?** _____

17. **How many times did you refill this medication?** _____

18. **Are you still taking this medication?** NO YES
    If YES, what is the current dose? (*example 5 mg*) _____

Thank you for your time.
Sincerely,

<SCQR NAME>

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