

Carer identified	<input type="checkbox"/> Yes; <input type="checkbox"/> Informal <input type="checkbox"/> Formal
	<input type="checkbox"/> No
Okay to contact carer	<input type="checkbox"/> Yes <input type="checkbox"/> No
Carer's details completed	<input type="checkbox"/> Yes <input type="checkbox"/> No
Carer consents to Awhina Study	<input type="checkbox"/> Yes <input type="checkbox"/> No
To return questionnaire to participant	<input type="checkbox"/> Yes <input type="checkbox"/> No

LILACS NZ



Life and Living in Advanced Age: A Cohort Study in New Zealand

Te Puāwaitanga o Ngā Tapuwae Kia Ora Tonu

~ WAVE 3 ~

This questionnaire has been developed by the LILACS NZ research team and is for the purpose of the LILACS NZ project. Please contact Professor Ngaire Kerse at the LILACS NZ research base.
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Visit record form

VISIT 1

Date:

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(dd) (mm) (yyyy)

Start Time: (24 hour time)

Finish Time: (24 hour time)

Who provided the responses to this questionnaire?

1=Participant 2=Family member 3=Other

Reason for proxy completing questionnaire

If a proxy completed the questionnaire, who answered most of the questions?

1=Participant told proxy the answers 2=Proxy used their own judgement

Place of interview:

1=Residence 2=Health centre 3=Other

Language used to answer questions:

1=English 2=Te reo Māori/bilingual 3=Other

VISIT 2

Date:

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 .

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 .

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(dd) (mm) (yyyy)

Start Time: (24 hour time)

Finish Time: (24 hour time)

Who provided the responses to this questionnaire?

1=Participant 2=Family member 3=Other

Reason for proxy completing questionnaire

If a proxy completed the questionnaire, who answered most of the questions?

1=Participant told proxy the answers 2=Proxy used their own judgement

Place of interview:

1=Residence 2=Health centre 3=Other

Language used to answer questions:

1=English 2=Te reo Māori/bilingual 3=Other

Visit record form

VISIT 3

Date:

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(dd) (mm) (yyyy)

Start Time: (24 hour time)

 Finish Time: (24 hour time)

Who provided the responses to this questionnaire?
 1=Participant 2=Family member 3=Other

Reason for proxy completing questionnaire

If a proxy completed the questionnaire, who answered most of the questions?
 1=Participant told proxy the answers 2=Proxy used their own judgement

Place of interview:
 1=Residence 2=Health centre 3=Other

Language used to answer questions:
 1=English 2=Te reo Māori/bilingual 3=Other

VISIT 4

Date:

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(dd) (mm) (yyyy)

Start Time: (24 hour time)

 Finish Time: (24 hour time)

Who provided the responses to this questionnaire?
 1=Participant 2=Family member 3=Other

Reason for proxy completing questionnaire

If a proxy completed the questionnaire, who answered most of the questions?
 1=Participant told proxy the answers 2=Proxy used their own judgement

Place of interview:
 1=Residence 2=Health centre 3=Other

Language used to answer questions:
 1=English 2=Te reo Māori/bilingual 3=Other

Life and Living in Advanced Age: A Cohort Study in New Zealand Te Puāwaitanga o Ngā Tapuwāe Kia Ora Tonu

LILACS NZ



NHI No:

Interviewer:

Date: . .
(dd) (mm) (yyyy)

1. Contact Details

Name

I would like to check some of the details you have given us previously

AA1. Do you still live at...
(refer sheet for previous address)

No=0 *(Record new address)* Yes=1 *(Go to AA2)*

Full Address
.....
..... Phone

AA2. Is *(refer sheet)* someone we could contact if we cannot get hold of you? If for example you moved or were away.

No=0 *(Record new contact)* Yes=1 *(Go to AA3)*

New contact
Name
Address
..... Phone
Relationship

AA3. Is *(refer sheet)* someone we could contact if we cannot get hold of you?

No=0 *(Record new contact)* Yes=1 *(Go to AB1)*

Different household for second contact if possible

Name
Address
..... Phone
Relationship

Interviewer: If only one contact recorded please ask if there is anyone else. Record new contact details in space

Interviewer:

2. Personal History

AB1. Is your GP still...

(refer sheet for previous GP)

No=0 (Record new contact) Yes=1 (Go to AB2)

If no please tell me your GP's name and address:

GP Name

GP Practice

.....

..... Phone

Interviewer: If no GP was recorded, please ask and record in the space

AB2. What is your current marital status?

I have never been married/partnered	Married/ partnered	Widow/Widower	Separated	Divorced	
1	2	3	4	5	<input type="checkbox"/>

AB3. Who do you live with most of the time?

1 = alone (Go to AB3b)

2 = with spouse/partner only

3 = with spouse and child/other relative

4 = with spouse and non relatives

5 = with child (not spouse)

6 = with other(s) not spouse or children

Who?

AB3a. If not living alone, how many people, including you, live in your residence/ household most of the time?

OR

AB3b. If living alone, how long have you lived alone

(years)

AB4. What best describes your home?

1 = private dwelling, stand alone house

2 = private unit or apartment - independent

3 = unit or apartment on site with family dwelling

4 = retirement village - villa or own unit

5 = rest home

6 = private hospital (own or shared room)

7 = Marae or iwi based housing

8 = other.....

MODIFIED MINI MENTAL STATE EXAMINATION (3MS)

I'd like to ask some questions that measure your attention, memory and ability to understand instructions. Some of the questions will be easy; others may be more difficult.

Interviewer: *Even if a proxy is in attendance, remember to ask this section of the participant themselves. Remind them they do not have to answer all the questions. Use the next page to help answer AE12, AE13, AE14 and the Clock Drawing Test*

AE1. When were you born?

Year	/1
Month	/1
Day	/1
Town	/1
Province/Region	/1

Where were you born?

(Score 1 point for each correct answer)

AE2. I would like to test your memory. I am going to say 3 words. Repeat them after I have said all three. Now keep those words in mind. I'm going to ask you to say them again in a few minutes.

Socks	/1
Blue	/1
Charity	/1

(When repeating back, allow up to 6 tries to remember, score 1 point for each correct answer)

AE3. Please count from 1 to 5. Now count backwards from 5 to 1.

/2

(Accurate – score 2; 1 or 2 errors – score 1)

AE4. Please spell the word 'WORLD' backwards.

D	/1
L	/1
R	/1
O	/1
W	/1

(Give only one chance, score 1 point for each letter in correct order)

SUB SCORE

/15

AE5. Please repeat back the three words I asked you to remember.

Socks	/3
Blue	/3
Charity	/3

(For each word: spontaneous recall – score 3, prompt – score 2, multiple choice – score 1)

- AE6. What year is this?** (*Accurate = 8, miss by 1 = 4, miss by 2-5 = 2*) Year

/8

What season is it? (*Accurate or within 1 month = 1*) Season

/1

What month is it? (*Accurate or within 5 days = 2, miss by 1 month = 1*) Month

/2

What is the date? (*Accurate = 3, miss by 1-2 days = 2, miss by 3-5 days = 1*) Date

/3

What day of the week is it? (*Accurate = 1*) Day

/1

SUB SCORE

/24

- AE7. Where are we now?** (Or what room are we in?) (*Accurate - score 1*) Room

/1

What region are we in? (*Accurate - score 2*) Province/Region

/2

What district is this? (*Accurate - score 1*) District

/1

What city (town) is this? (*Accurate - score 1*) City

/1

- AE8. What is this?** pencil

/1

(Point to the item or body part. Score 1 for each correct answer, approximate answers such as 'pen', 'arm', 'hand' are not acceptable) watch

/1

shoulder

/1

elbow

/1

knuckle

/1

SUB SCORE

/10

- AE9. You have thirty seconds to answer this next question. Naming as many animals as you can, what animals have 4 legs?** (*1 point each. Discontinue after 30 seconds*)

--

.....

SUB SCORE

/10

- AE10. In what way are an arm and a leg alike?** e.g. Body part, limb

/2

In what way are laughing and crying alike? e.g. feeling, emotion

/2

In what way are eating and sleeping alike? e.g. essential for life

/2

(Accurate - score 2 each example, less correct - score 1 for each)

- AE11. Please repeat the following - "no ifs, ands or buts"** correct

/5

(Allow only 1 trial)



AE12. Please read this and do what it says.

(Obey without prompt - score 3, prompt - score 2, can read aloud and obey - score 1)

AE13. Please write a sentence - it can say anything you like.

The sentence must contain a subject, a verb and be sensible. Correct grammar and punctuation are not necessary. Prompts permitted if necessary. Score 5 for a complete sentence.

SUB SCORE /19

AE14. Please copy this drawing exactly as it is. (Ignore tremor and rotation)

- For each figure: approximately equal sides=4; 5 unequal sides=3; other enclosed figure=2; 2 or more lines=1
- 4 corner enclosure: 4 corners=2; not 4 corners=1 or 0

/10

Hold out a piece of paper (use the blank side of diagram page) to the participant. AE15. Take this paper in your right hand, fold it in half, and hand it back to me

R hand /1
fold /1
Gave back /1

AE16. What three words did I ask you to remember earlier?

(Spontaneous recall = 3, prompt = 2, multiple choice = 1)

Socks /3
Blue /3
Charity /3

SUB SCORE /22

TOTAL 3MS SCORE /100

CLOCK DRAWING

AE17. Please imagine this circle is a clock. I would like you to place the numbers in the correct position then place the hands to indicate a time of 'ten past eleven'

0 =No errors 1 = minor spacing errors 2 = other errors

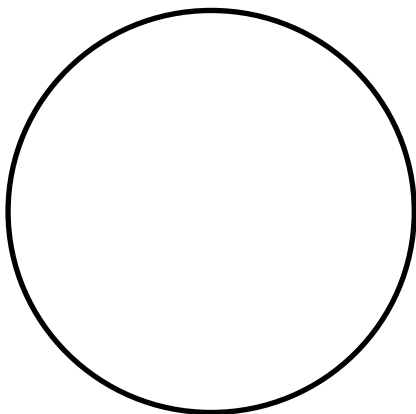
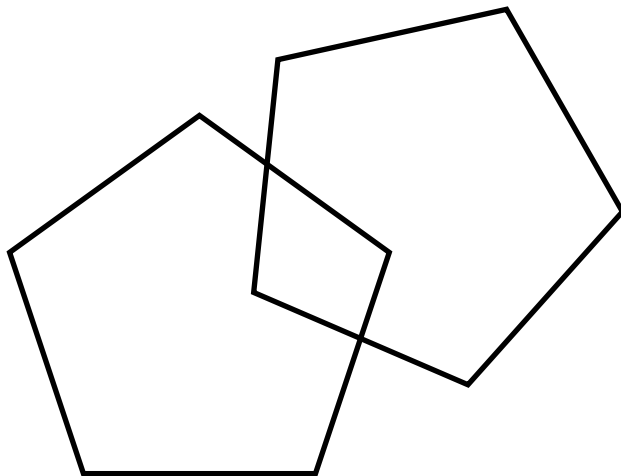
Comments

Interviewers: For those who have a score of less than 65 on the 3MSE it is strongly recommended that they are supported by a family member or friend to help answer the questions. If no-one is available and the interview is going well, please continue

Tear along dotted line

Please write a sentence about anything.

.....
.....
.....
.....



OCCUPATION

The next questions ask about the work you may have done, both paid and unpaid.

AG10. During the past 7 days, did you work for pay or as a volunteer?

Neither <i>(Go to AG11)</i>	Yes, for pay	Yes, as a volunteer	Yes, both for pay and as a volunteer	
1	2	3	4	<input type="checkbox"/>

AG10a. How many hours in the last 7 days did you work for pay or as a volunteer?

a. Hours in the last 7 days worked for pay	<input type="text"/>	<input type="text"/>
b. Hours in the last 7 days worked as a volunteer	<input type="text"/>	<input type="text"/>
TOTAL hours in the last 7 days <i>(Go to AG12)</i>	<input type="text"/>	<input type="text"/>

AG11. If you haven't worked for pay or as a volunteer in the last week, during the past MONTH, did you work for pay or as a volunteer?

Neither <i>(Go to BA1)</i>	Yes, for pay	Yes, as a volunteer	Yes, both for pay and as a volunteer	
1	2	3	4	<input type="checkbox"/>

AG11a. How many hours in the last month did you work for pay or as a volunteer?

a. Hours in the last month worked for pay	<input type="text"/>	<input type="text"/>
b. Hours in the last month worked as a volunteer	<input type="text"/>	<input type="text"/>
TOTAL hours in the last month	<input type="text"/>	<input type="text"/>

AG12. Which of the following categories best describes the amount of physical activity required on your job/volunteer work?

(answer this for the job you do spend most hours doing)

- 1=Mainly sitting with slight arm movements. (E.g. office worker, watchmaker, seated, assembly worker, bus driver, Marae spokesperson).
- 2=Sitting or standing with some walking. (E.g. cashier, general office worker).
- 3=Walking, with some handling of materials weighing less than 50 pounds/20kg. (E.g. postie, waiter / waitress).
- 4=Walking and heavy manual work often requiring handling of materials weighing over 50 pounds/20kg. (E.g. forestry, farm or general labourer).

Comments

.....

.....

.....

.....

.....

3. Physical Health

SF-12

These next questions ask for your views about your health. This information will help keep track of how you feel and how well you are able to do your usual activities. If you are unsure about how to answer a question, please give the best answer you can.

BA1. In general, would you say your health is:

2	Excellent	Very Good	Good	Fair	Poor	
	1	2	3	4	5	

BA2. The following questions are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much?

	Yes, limited a lot	Yes, limited a little	No, not limited at all	
a. Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf	1	2	3	
b. Climbing several flights of stairs	1	2	3	

BA3. During the PAST 4 WEEKS, how much of the time have you had any of the following problems with your work or other regular daily activities AS A RESULT OF YOUR PHYSICAL HEALTH?

3		All of the time	Most of the time	Some of the time	A little of the time	None of the time	
	a. Accomplished less than you would like	1	2	4	5	6	
	b. Were limited in the kind of work or other activities	1	2	4	5	6	

BA4. During the PAST 4 WEEKS, how much of the time have you had any of the following problems with your work or other regular daily activities AS A RESULT OF ANY EMOTIONAL PROBLEMS (such as feeling depressed or anxious)?

	All of the time	Most of the time	Some of the time	A little of the time	None of the time	
a. Accomplished less than you would like	1	2	4	5	6	
b. Did work or activities less carefully than usual	1	2	4	5	6	

BA5. These questions are about how you feel and how things have been with you DURING THE PAST 4 WEEKS For each question, please give the one answer that comes closest to the way you have been feeling. How much of the time during the PAST 4 WEEKS.

	All of the time	Most of the time	Some of the time	A little of the time	None of the time	
1. Have you felt calm and peaceful?	1	2	4	5	6	<input type="checkbox"/>
2. Did you have a lot of energy?	1	2	4	5	6	<input type="checkbox"/>
3. Have you felt downhearted and depressed?	1	2	4	5	6	<input type="checkbox"/>

BA6. During the PAST 4 WEEKS, how much did PAIN interfere with your normal work (including both work outside the home and housework)?

Not at all	Slightly	Moderately	Quite a bit	Extremely	
1	2	3	4	5	<input type="checkbox"/>

4

BA7. During the PAST 4 WEEKS, how much of the time has your PHYSICAL HEALTH OR EMOTIONAL PROBLEMS interfered with your social activities (like visiting with friends, relatives, etc)?

All of the time	Most of the time	Some of the time	A little of the time	None of the time	
1	2	3	4	5	<input type="checkbox"/>

SLEEPING AND HEALTH PROBLEMS

CD1. Do you have trouble with your sleeping (on at least 3 nights per week) such that it interferes with your activities the following day (e.g. un-refreshed in the morning, fatigue, poor concentration or irritability)?

No=0 (Go to BB1) Yes=1

CD2. Do you have any of these sleeping problems? (read all options)

(No=0 Yes=1)

- Waking up in the early hours of the morning
- Lying awake for most of the night
- Taking a long time to get to sleep
- Worry keeping you awake at night
- Sleep walking/ sleep talking
- Snoring
- Getting up at night to go to the toilet

On average, how many times a night

Other sleeping problem

The next questions ask about conditions you have had for 6 months or more

BB1. Does a HEALTH PROBLEM, or a condition you have (lasting SIX MONTHS or more) cause you difficulty with, or stop you doing: (No=0 Yes=1)

- Everyday activities that people your age can usually do
- Communicating, mixing with others or socialising
- Any other activity that people your age can usually do

BB3. In general, compared with other people your age, would you say your health is:

2	Excellent	Very Good	Good	Fair	Poor	
	1	2	3	4	5	<input style="width: 20px; height: 20px;" type="checkbox"/>

NOTTINGHAM EXTENDED ACTIVITIES OF DAILY LIVING

The next questions ask about a few more common everyday activities. For each question please tell me whether you do the activity on your own, on your own with difficulty, with help from someone else, or whether you don't do the activity at all. We are interested in whether you have actually DONE the activity in the last few weeks, not whether you CAN do it.

Interviewer: ask all the questions first. Then go back to all activities the person said they have help to do. For each activity they said they have help to do, find out who helps.

Scoring:
No = 0
With help = 1

On my own; on my own with difficulty = 2

Help received from...

Someone in the same household	Family outside the household	Others
-------------------------------------	------------------------------------	--------

	Mobility				
BC1.	a. Do you walk around outside?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	b. Do you climb stairs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	c. Do you get in and out of the car?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	d. Do you walk over uneven ground?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	e. Do you cross roads?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	f. Do you travel on public transport?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
BC2.	In the kitchen				
	a. Do you manage to feed yourself?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	b. Do you manage to make yourself a hot drink?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	c. Do you take hot drinks from one room to another?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	d. Do you do the washing up?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	e. Do you make yourself a hot snack?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
BC3.	Domestic tasks				
	a. Do you manage your own money when you are out?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	b. Do you wash small items of clothing?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	c. Do you do your own housework?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	d. Do you do your own shopping?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	e. Do you do a full clothes wash?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
BC4.	Leisure activities				
	a. Do you read newspapers or books?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	b. Do you use the telephone?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	c. Do you write letters?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	d. Do you go out socially?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	e. Do you manage your own garden?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	f. Do you drive a car?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
BC5.	Other				
	a. Do you manage your personal care for instance brushing your teeth and hair, washing your hands and face?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	b. Do you manage to go to the toilet?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	c. Do you get in/out of bed?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	d. Do you shower/bath yourself?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	e. Do you dress yourself?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

BC6. Do you use a mobility scooter?

No=0; Yes=1

4. Medical History

In this section I would like to find out about things to do with medication and your medical history.

MEDICATIONS

The first questions are about medications and non-prescribed products you might use as well as any health problems you may have. Remember that any question you are not happy to answer, you may leave.

Interviewer:

Ask the following questions and record all medications and health products, whether they are prescribed or not, in the table to the right. Include inhalers, suppositories, creams, eye drops etc. You may need to prompt the participant about these more unusual products. Ask if you can look at the medication packets and fill in as much information as you can. See the procedure manual for further guidance on completing this section.

CA1. Do you currently take any medications prescribed by the doctor?

5

No=0 (Go to CA3) Yes=1

		Never	Rarely	Sometimes	Often	Very often	
CA1a.	Sometimes people forget to take their medicines. How often do <i>you</i> forget to take your medication(s)?	1	2	3	4	5	<input type="checkbox"/>
CA1b.	Sometimes people alter the way they take their medication, that is take them at a different time or take less or more of a medication. How often do <i>you</i> alter you medication(s)?	1	2	3	4	5	<input type="checkbox"/>

CA3. Do you currently take any over the counter medicines that are not prescribed?

No=0 Yes=1

CA4. Do you currently take any nutritional supplements?

No=0 Yes=1

CA5. Do you take any “natural” or “herbal” products or traditional medicines?

No=0 Yes=1

CA6. Do you take any Rongoa Māori medicines?

No=0 Yes=1

MEDICATION ASSISTANCE AND HEART HEALTH

CA7. Do you use any aids to help you take your *prescribed* medication?

No=0 *(Go to CB1)* Yes=1

CA7a. What type of aid do you use?

No=0; Yes=1

Blister pack
 Yellow card

Weekly medication boxes
 Other

CB1. Since your last LILACS NZ interview about a year ago, have you been told by a doctor that you have had:

CB3. Were you in hospital for this?

No=0; Yes=1; Don't Know=2

No=0; Yes=1

a. Heart attack/myocardial infarction	
b. Angina	
c. Stroke	
d. Transient Ischemic Attack / mini stroke	
e. Atrial fibrillation or irregular heartbeat	
f. Congestive heart failure	
g. Intermittent claudication (pain in calves when walking), peripheral vascular disease	

MAJOR LIFE EVENTS

These next two questions ask about major health events you may have experienced

FD1. Have you had a major injury or health event that has affected you since your last LILACS NZ interview about a year ago?

No=0 *(Go to FD2)* Yes=1

FD1a. What was it?

.....

FD2. Have you had a major psychological stress event that has affected you since your last LILACS NZ interview about a year ago? For example the unexpected loss of a family member or moving house

No=0 *(Go to CF1)* Yes=1

FD2a. What was it?

.....

FALLS, CONTINENCE, AND HEALTH HABITS

The next questions are about falls

CF1. How many times have you fallen in the last 12 months?

None <i>(Go to CF11)</i>	One	Two or three	Four or more	
0	1	2	3	<input type="checkbox"/>

CF1a. Have you sought medical attention because of your fall/s? No=0; Yes=1

CF1b. When you fell during the last 12 months? No=0; Yes=1

- a. Did you have a fracture
- b. Did you have some other kind of injury (please describe)
-
- c. Were you admitted to hospital?

CF11. Have you had any fracture not from a fall since your last LILACS NZ interview about a year ago? No=0; Yes=1

CF11a. Cause of fracture

.....

CF2. How confident are you that you can do all your daily activities without falling?

Not at all confident	Quite confident	Completely confident	
0	1	2	<input type="checkbox"/>

I want to ask you about any bladder and bowel problems you might have

CF3. Do you have a problem with losing control of urine when you don't want to? No=0 *(Go to CF4)* Yes=1

CF3a. How much of a problem would you say you have with losing control of urine?

Severe problem	Moderate problem	Mild problem <i>(Go to CF4)</i>	No problem <i>(Go to CF4)</i>	
1	2	3	4	<input type="checkbox"/>

CF3b. Have you sought help for this? No=0; Yes=1

Your GP

District nurse

Pharmacy

Other

CF4. Do you have a problem with losing control of your bowels when you don't want to? No=0; Yes=1

CC1. Do you smoke cigarettes?

No=0 (Go to DE1); Yes=1

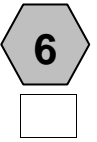
CC1c. On average, how many cigarettes do you smoke per day? One pack is 20 cigarettes

DE1. How often do you have a drink containing alcohol?

Never	Monthly or less	Two to four times a MONTH	Two to three times a WEEK	Four or more times a WEEK	
0	1	2	3	4	<input type="checkbox"/>

I'm going to ask you a question about breathlessness. I ask it now because we want you to rate how breathless you are feeling while you are relaxed. I will also ask you about your perception of exertion later while you are doing some physical activity.

Please look at this rating scale; we want you to use this scale from 6 to 20, where 6 means 'no breathlessness at all' and 20 means 'maximal breathlessness'. Look at the scale and the expressions and then give a number.



BD4. Thinking of your breathlessness right now, how would you rate your feeling of breathlessness?

Comments

.....

.....

.....

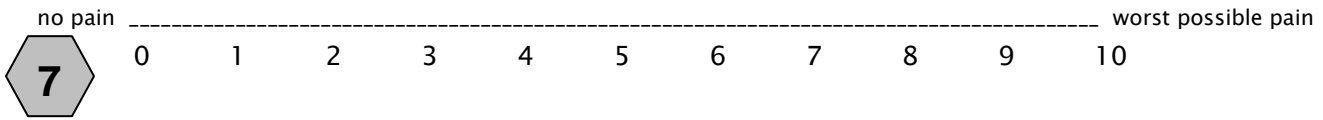
.....

.....

PAIN

I'd like to ask a few questions about pain now. I'm going to ask for some detail about each area that you have pain in. Use the following scale to determine the level of pain.

Example



CG0. Do you have any pain now?

No=0 *(Go to CG6)* Yes=1

Where is it? *(Interviewer: Use the scale and map supplied to code all pain mentioned by area and write each area in the table below)*

Area	CG1	CG2	CG3	CG4	CG5
a.					
b.					
c.					
d.					
e.					
f.					
g.					
h.					

Interviewer - ask these questions about each area before you go on to the next

CG1. What is your pain RIGHT NOW?

CG2. What is your TYPICAL or AVERAGE pain?

CG3. What is your pain level AT ITS BEST (How close to '0' does your pain get at its best)?

CG4. What is your pain level AT ITS WORST (How close to '10' does your pain get at its worst)?

CG5. How many days over the last month have you had this pain?

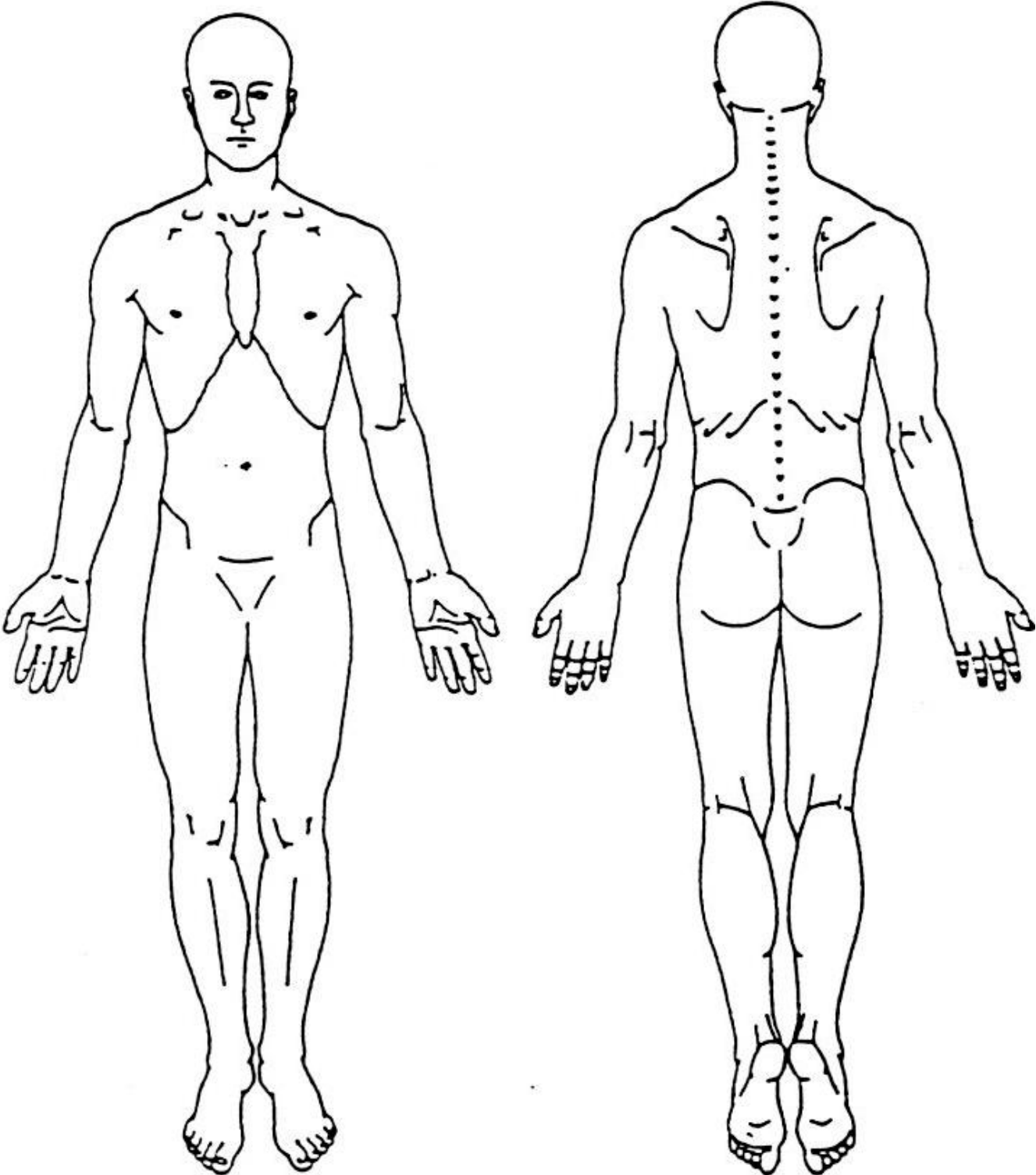
CG6. Are there any other areas you sometimes have pain but do not have pain right now?

No=0 *(Go to EA1)* Yes=1

Interviewer, code other areas of pain and ask CG2–CG5 above for each area mentioned

Area	CG1	CG2	CG3	CG4	CG5
i.	0				
j.	0				
k.	0				
l.	0				
m.	0				
n.	0				
o.	0				

Ask participant to shade or circle the location of each area of pain. Place letter of area (a - o) beside shading or circle.



5. Mental Health

GERIATRIC DEPRESSION SCALE (15-items)

The next questions are from a scale used in many studies and are about how you have been feeling lately. Please choose the best answer to describe how you have felt over the past WEEK.

No=0; Yes=1

EA1. Are you basically satisfied with your life?	
EA2. Have you dropped many of your activities and interests?	
EA3. Do you feel that your life is empty?	
EA4. Do you often get bored?	
EA5. Are you in good spirits most of the time?	
EA6. Are you afraid that something bad is going to happen to you?	
EA7. Do you feel happy most of the time?	
EA8. Do you often feel helpless?	
EA9. Do you prefer to stay at home, rather than going out and doing new things?	
EA10. Do you feel you have more problems with memory than most?	
EA11. Do you think it is wonderful to be alive now?	
EA12. Do you feel pretty worthless the way you are now?	
EA13. Do you feel full of energy?	
EA14. Do you feel that your situation is hopeless?	
EA15. Do you think that most people are better off than you are?	

6. Support needs

VISITS TO HEALTH PROFESSIONALS

Thank you for answering the questions about medical conditions. I'd now like to ask you about visits to health professionals.

GA1. If you have any health problems, which one would you most like to be fixed?

.....
(if no problems Go to GA2)

GA1a. Is a health professional helping/trying to help you with this problem?

No=0; Yes=1

GA2. Since your last LILACS NZ interview about a year ago, have you visited, or had a visit from, any of the following health professionals? How many times in the last 12 months?

8

	Not at all	About once a year	About every 6 months	About every 3 months	About every month	About every week	Don't know	
a. General practitioner	0	1	2	3	4	5	6	
b. Hospital based doctor or private specialist	0	1	2	3	4	5	6	
c. After hours medical clinic	0	1	2	3	4	5	6	
d. Practice nurse	0	1	2	3	4	5	6	
e. Pharmacist/chemist	0	1	2	3	4	5	6	
f. Dentist	0	1	2	3	4	5	6	
g. Podiatrist – feet	0	1	2	3	4	5	6	
h. Audiologist – ears/hearing	0	1	2	3	4	5	6	
i. Optometrist – eyes glasses	0	1	2	3	4	5	6	
j. District Nurse	0	1	2	3	4	5	6	
k. Physiotherapist	0	1	2	3	4	5	6	
l. Occupational Therapist	0	1	2	3	4	5	6	
m. Dietician	0	1	2	3	4	5	6	
n. Social worker	0	1	2	3	4	5	6	
o. Community worker	0	1	2	3	4	5	6	
p. Whānau ora worker	0	1	2	3	4	5	6	
q. Alternative health professional e.g. Naturopath/ Homeopath	0	1	2	3	4	5	6	
r. Tohunga / Maori healer	0	1	2	3	4	5	6	
s. Other health professional. Specify:	0	1	2	3	4	5	6	

HEARING/VISION/TEETH

I'd like to ask three questions about your hearing, your eyesight and your teeth now.

GB1. How much does your hearing interfere with normal day-to-day functioning?

10	Not at all	Somewhat	Moderately	Very	Extremely	
	1	2	3	4	5	<input type="checkbox"/>

GB2. Do you have a hearing aid?

No=0 (*Go to GB3*); Yes=1

GB2a. How often do you use it?

None of the time	Some of the time	Most of the time	All of the time	
0	1	2	3	<input type="checkbox"/>

GB3. How much does your eyesight interfere with normal day-to-day functioning?

10	Not at all	Somewhat	Moderately	Very	Extremely	
	1	2	3	4	5	<input type="checkbox"/>

GB4. How much do your teeth interfere with normal day-to-day functioning?

Not at all	Somewhat	Moderately	Very	Extremely	
1	2	3	4	5	<input type="checkbox"/>

SOCIAL SUPPORT

Now I'd like to ask you some questions about your social network and social relationships.

GC1. When you need some extra help, can you count on anyone to help with daily tasks like grocery shopping, cooking, house cleaning, telephoning, give you a ride?

No (<i>Go to GC4</i>)	Yes	I don't need help	
0	1	2	<input type="checkbox"/>

GC2. In the last year who has been most helpful with these daily tasks?

- 1 = Spouse 2 = Daughter 3 = Son
- 4 = Sibling 5 = Other relative 6 = Your neighbours
- 7 = Co-workers 8 = Church members 9 = Club members
- 10 = Professionals 11 = Any friend not included in these categories
- 12 = No-one

GC4. Can you count on anyone to provide you with emotional support? (e.g. talking over problems or helping you make a difficult decision)

No (<i>Go to GC15</i>)	Yes	I don't need help	
0	1	2	<input type="checkbox"/>

Instruction for interviewer:

- (I) Please tick boxes "☑" on the front page whether 1) a carer (formal or informal) is identified, 2) participant agrees for us to contact the carer and 3) carer's contact details are provided.
- (II) Remember to contact the identified carer if they are not present to inform them about the AWHINA (LOVE & SUPPORT) STUDY and to obtain a written informed consent.

GC8. How satisfied are you with the kinds of relationships you have with your family?

11	Extremely dissatisfied	Very dissatisfied	Somewhat dissatisfied	Satisfied most of the time	Satisfied all of the time	
	1	2	3	4	5	

GC9. How satisfied are you with the kinds of relationships you have with your friends?

Extremely dissatisfied	Very dissatisfied	Somewhat dissatisfied	Satisfied most of the time	Satisfied all of the time	
1	2	3	4	5	

GC16. What funded/subsidised government/community services are available for older people in your area? (Do not prompt for answers)

		<i>(No=0; Yes=1)</i>
Buses/taxis	<input type="checkbox"/>	Meal support
Home help (cleaning)	<input type="checkbox"/>	Age Concern
Home Help (shopping)	<input type="checkbox"/>	Stroke Foundation
Home Help (gardening)	<input type="checkbox"/>	Foundation of the Blind
Home Help (lawn mowing)	<input type="checkbox"/>	Alzheimer's Association
Personal Care (bathing/dressing etc.)	<input type="checkbox"/>	Other
Other	<input type="checkbox"/>	Other

Comments

.....

.....

GC17. Do you use a medical alarm?

No=0; Yes=1

If living in a rest home or private hospital Go to GC12

GC10. Do you receive any regular support service, such as home help?

No=0 (Go to GC12); Yes=1

GC11. Do you receive any of the following support services?

IF Yes: How often? Who funds this help?

(For each service received, ask who the support is received from. Record the frequency in the appropriate column - there may be more than one service provider)

	A. Receive No=0 Yes=1	B. Frequency 1=Several times a day 2=Once a day 3=One or more times a week 4=Less than once a week	C. Support provided by 1=public system 2=part of accommodation cost 3=respondent pays 4=family pays
a. Any meal service	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Home Help (cleaning)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Home Help (shopping)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Home Help (gardening)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Personal Care (bathing/dressing etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

GC12. How often do you currently provide care or assistance for other people?

Never	Occasionally (less than weekly)	Once a week	Two to five times weekly	Daily (six to seven times weekly)	
0	1	2	3	4	<input type="checkbox"/>

FA1. All things considered, how satisfied are you with your life as a whole these days

Very dissatisfied	Dissatisfied	Neither satisfied nor dissatisfied	Satisfied	Very satisfied	
1	2	3	4	5	<input type="checkbox"/>

12

7. End of life

Interviewer: Remind the participant that he/she has the right not answer or not to proceed with this section at any time

Now I want to ask you about your plan for the end of your life.

EL1. Are you comfortable talking about this? No=0 (Go to Section 8); Yes=1

EL2. Do you want to continue? No=0 (Go to Section 8); Yes=1

EL3. Have you made a Will? No=0; Yes=1

EL4. Do you have a Living Will or Advanced Care Plan? (Go to EL5); No=0; Yes=1

EL4a. If yes,

	No	Yes	
a. Do you have an Enduring Power of Attorney?	0	1	<input type="checkbox"/>
b. Do you wish for major surgery or medical intervention if you are seriously ill?	0	1	<input type="checkbox"/>
c. Do you wish to be resuscitated?	0	1	<input type="checkbox"/>
d. Other	0	1	<input type="checkbox"/>

EL5. Have you talked to a friend or family member about your wishes? No=0 (Go to EL6); Yes=1

EL5a. If yes, who did you talk to? (you can choose more than one) (No=0; Yes=1)

Spouse Son Daughter Other family member
 Close friend Lawyer Others:

Questions EL6, EL7, EL8 are for Māori participants only. For non-Māori, Go to EL9

EL6. Will you be having a Tangihanga?

No (Go to EL7)	Yes	Maybe	
0	1	2	<input type="checkbox"/>

EL6a. If yes, on which Marae?

Name:

Your ancestral Marae	Your spouse's ancestral Marae	Another Marae	
1	2	3	<input type="checkbox"/>

EL7. Will you be buried in the Urupa?

No=0 (*Go to EL8*); Yes=1

EL7a. If "yes", in which Urupa?

Name:

Your ancestral Urupa	Your spouse's ancestral Urupa	Another Urupa	
1	2	3	

EL8. Are there any other rituals that are important to you after death? (*Read our all options*)

	No	Yes	Don't know	
a. Ukaipo (return the body to the home land)	0	1	777	<input type="checkbox"/>
b. Kawemate (return the spirit)	0	1	777	<input type="checkbox"/>
c. Hura Kōhatu (unveiling)	0	1	777	<input type="checkbox"/>
d. Other	0	1	777	<input type="checkbox"/>

Ask ALL participants

Thinking about what will happen at the end of your life, are you happy to talk about this?

EL9.

No (<i>Go to Section 8</i>)	Yes	
0	1	

EL10. Who would you like to care for you while you are dying? (you can choose more than one person) (No=0; Yes=1) 23

My spouse/partner <input type="checkbox"/>	My son(s) <input type="checkbox"/>	My daughter(s) <input type="checkbox"/>
My grandchildren <input type="checkbox"/>	Other family members <input type="checkbox"/>	Close friend <input type="checkbox"/>
Paid caregivers <input type="checkbox"/>	I don't know <input type="checkbox"/>	

EL11. Will there be spiritual practices while you are dying?

No=0 (*Go to EL12*); Yes=1

EL11a. If yes, who will undertake these practices? (you can choose more than one person)

Family member <input type="checkbox"/>	Minister of the church <input type="checkbox"/>
Tohunga <input type="checkbox"/>	Other: <input type="checkbox"/>

EL12. Where would you like to die (what place)? (you can choose more than one) (No=0; Yes=1)

		At home
	24	In a public hospital
		In a whānau/family room in a public hospital
		In a rest home/private hospital
Some other place:		At a family member home (not where you live now)
		At your Turangawaewae (tribal home)
		At a spiritual place that is special for you
		In a hospice
		Other, specify

EL13. Who would you like to take care of your body after you die? (you can choose more than one person) (No = 0 Yes = 1)

25	My spouse/partner <input type="checkbox"/>	My son(s) <input type="checkbox"/>	My daughter(s) <input type="checkbox"/>
	My grandchildren <input type="checkbox"/>	My close friends <input type="checkbox"/>	Funeral director <input type="checkbox"/>
	I do not want to answer <input type="checkbox"/>	Other person, specify	

EL14. Have you made plans for the funeral? No=0 (Go to EL15) Yes=1

EL14a. If yes, have you made financial arrangements for the funeral? No=0 Yes=1

EL15. Who would you like to organise the funeral service? (you can choose more than one person) (No = 0 Yes = 1)

26	My spouse/partner <input type="checkbox"/>	My son(s) <input type="checkbox"/>
	My daughter(s) <input type="checkbox"/>	My paid caregiver <input type="checkbox"/>
	My family and whānau <input type="checkbox"/>	The minister of the local church <input type="checkbox"/>
	My lawyer <input type="checkbox"/>	Funeral director <input type="checkbox"/>
	Other person, specify	

EL16. Where do you want to lie before your funeral service? (you can choose more than one) (No = 0 Yes = 1)

At home <input type="checkbox"/>	In the church <input type="checkbox"/>	In the funeral home <input type="checkbox"/>
At the Marae <input type="checkbox"/>	Other place, specify	

EL17. Would you wish for a burial or cremation?

Burial (Go to EL17a)	Cremation (Go to EL17b)
1	2
	<input type="checkbox"/>

EL17a. Where will you be buried?

- 1=Local cemetery
- 2=Other cemetery. If other, what is the reason?
- 3=Elsewhere (e.g. burial at sea)
- 777=Don't know

EL17b. What will happen to the ashes?

- 1=Ashes will be buried in the cemetery
- 2=Ashes will be scattered in a special place
- 3=Ashes will be stored at home

10

EL18. How important would the following be for you at the end of your life?

	Not at all	Somewhat	Moderately	Very	Extremely	
a. To have my pain/symptoms well controlled	1	2	3	4	5	<input type="checkbox"/>
b. To not be a burden to my family	1	2	3	4	5	<input type="checkbox"/>
c. To feel my life is complete	1	2	3	4	5	<input type="checkbox"/>
d. To be at peace with my God	1	2	3	4	5	<input type="checkbox"/>
e. To have sorted out my personal affairs	1	2	3	4	5	<input type="checkbox"/>
f. To die at home	1	2	3	4	5	<input type="checkbox"/>
g. To be mentally alert (until death)	1	2	3	4	5	<input type="checkbox"/>
h. To be involved in decisions about my care	1	2	3	4	5	<input type="checkbox"/>
i. To have sorted out my funeral arrangements	1	2	3	4	5	<input type="checkbox"/>
j. To not be a burden to society	1	2	3	4	5	<input type="checkbox"/>
k. To have specific cultural practices undertaken	1	2	3	4	5	<input type="checkbox"/>
l. To have sorted out the continuing care of my pet(s)	1	2	3	4	5	<input type="checkbox"/>
m. Other, specify	1	2	3	4	5	<input type="checkbox"/>

EL19. Now, how do you feel about having talked about planning for the end of life?

Very comfortable	Comfortable	Neither comfortable nor uncomfortable	Uncomfortable	Very uncomfortable	
1	2	3	4	5	<input type="checkbox"/>

EL20. Are you comfortable for us to contact [*carer nominated in previous section*] after your death to find out whether your hopes and wishes have been carried through?

No=0 Yes=1

8. Physical performance measures

SHORT PHYSICAL PERFORMANCE BATTERY

<i>Reason not attempted or not completed</i>	<i>CODE</i>
Tried but unable	1
Participant could not hold position unassisted	2
Not attempted, you felt unsafe	3
Not attempted, participant felt unsafe	4
Participant unable to understand instructions	5
Other (specify)	6
Participant refused	7

Now I'd like to ask you to do some physical performance tests. I will first describe and show each movement to you. Then I'd like you to try to do it. If you cannot do a particular movement or you feel it would be unsafe to try to do it, tell me and we'll move on to the next one. Let me emphasise that I do not want you to try to do any exercise that you feel might be unsafe.

BALANCE TEST

Instructions: Start with B: Semi-tandem stand. If the person cannot hold the position for 10 seconds, ask them to attempt A: Side-by-side stand. If they manage the semi-tandem stand for 10 seconds, go straight to C: Tandem stand.

Number of seconds held:	Held for 10 sec No=0 Yes=1	If not attempted or failed, enter reason: <i>(Code box above)</i>
-------------------------	----------------------------------	--

A. Side-by-side stand I want you to try to stand with your feet together, side by side, for about 10 seconds.	<input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>

If not attempted or not held for 10 seconds, end balance tests and go to gait speed test

Number of seconds held:	Held for 10 sec No=0 Yes=1	If not attempted or failed, enter reason: <i>(Code box above)</i>
-------------------------	----------------------------------	--

B. Semi-Tandem Stand Now I want you to try to stand with the side of the heel of one foot touching the big toe of the other foot for about 10 seconds. You may put either foot in front, whichever is more comfortable for you.	<input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>

If not attempted or not held for 10 seconds, end balance tests and go to gait speed test

	Number of seconds held:	Held for 10 sec No=0 Yes=1	If not attempted or failed, enter reason: <i>(Code box above)</i>
C. Tandem Stand Now I want you to try to stand with the heel of one foot in front of and touching the toes of the other foot for about 10 seconds. You may put either foot in front, whichever is more comfortable for you.	<input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>

GAIT SPEED TEST

Now I am going to observe how you normally walk. This is our walking course. I want you to walk to the other end of the course at your usual speed, just as if you were walking down the street to go to the store. Walk all the way past the other end of the tape before you stop.

Test was attempted	No=0	Yes = 1	First walk	Second walk
			<input type="checkbox"/>	<input type="checkbox"/>
Time for 3 metres (seconds)			<input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/>
Aids for walk (None=1; Cane=2; Walker=3; Other=4)			<input type="checkbox"/>	<input type="checkbox"/>
If not attempted or failed, enter reason <i>(Code box above)</i>			<input type="checkbox"/>	<input type="checkbox"/>

If not attempted or failed, go to chair stand test

CHAIR STAND TEST

Let's do the last movement test. Do you think it would be safe for you to try to stand up from a chair without using your arms?

Remember to have card 13 available

Remember that I said earlier that I would ask you about your perception of exertion while you are doing physical activity. While doing the chair stand test we want you to rate your perception of exertion, i.e., how heavy and strenuous the exercise feels to you. The perception of exertion depends mainly on the strain and fatigue in your muscles and on your feeling of breathlessness or aches in the chest. Please look at this rating scale; we want you to use this scale from 6 to 20, where 6 means 'no exertion at all' and 20 means 'maximal exertion'.

- 9 corresponds to 'very light' exercise. For a normal, healthy person it is like walking slowly at his or her own pace for some minutes.
- 13 on the scale is 'somewhat hard' exercise, but it still feels OK to continue.
- 17 'very hard' is very strenuous. A healthy person can still go on, but he or she really has to push him- or herself. It feels very heavy, and the person is very tired.
- 19 on the scale is an extremely strenuous exercise level. For most people this is the most strenuous exercise they have ever experienced.

Try to appraise your feeling of exertion as honestly as possible, without thinking about what the actual physical load is. Don't underestimate it, but don't overestimate it either. It's your own feeling of effort and exertion that's important, not how it compares to other people's. What other people think is not important either. Look at the scale and the expressions and then give a number.

Any questions?

So let's do the test. This test measures the strength in your legs. First, fold your arms across your chest and sit so that your feet are on the floor; then stand up keeping your arms folded across your chest.

(Single Chair Stand Test)

Safe to stand without help (No=0; Yes=1)

Results Participant stood without using arms

Go to Repeated Chair Stand Test

Participant used arms to stand

End test

Test not completed

End test

If not attempted or failed, code reason

.....

(Code box above)

Please stand up as QUICKLY as you can 5 times without stopping in between. After standing up each time, sit down and then stand up again. Keep your arms folded across your chest. I'll be timing you with a stopwatch.

(Repeated Chair Stand Test)

Safe to stand five times (No=0; Yes=1)

Time to complete five stands (in seconds)

 .

If not attempted or failed, code reason

.....

(Code box above)

Interviewer: ask immediately after completing all physical tests the participant can do.

HC1. So, thinking of your feeling of exertion right now, how would you rate your feeling of exertion?



9. Housing and Environment

We know that people’s living environments are closely related to their health and well-being. We also know that people often move as they get older. The next questions now are about your house and about changing where you live.

IB1. Has your place of residence changed since your last LILACS NZ interview about a year ago? No=0 *(Go to IB6)* Yes=1 *(continue)*

If ‘Yes’ to question IB1... and if more than one move, ask about last move only

IB2. When did you move? Date or best estimate . .
(dd) (mm) (yyyy)



IB3. Why did you choose your current residence? No=0; Yes=1

Size of home	<input type="checkbox"/>
Better safety and security	<input type="checkbox"/>
To free up money or equity	<input type="checkbox"/>
Easier maintenance of house and or gardens	<input type="checkbox"/>
Closer to shops, post office, or other amenities	<input type="checkbox"/>
Closer to health services eg. your GP	<input type="checkbox"/>
Nicer environment eg view, climate, weather	<input type="checkbox"/>
To be near or with children	<input type="checkbox"/>
To be near or with other relatives	<input type="checkbox"/>
To be near or with friends	<input type="checkbox"/>
Returning to family/whānau land	<input type="checkbox"/>
Other	<input type="checkbox"/>

IB4. Was there any one event that made it important to move? No=0; Yes=1
If ‘No’, go to IB14

If ‘Yes’ to question IB4:

IB5. What event was that? Do not read, Do not prompt but put a 1 for each event identified

Death or illness of spouse or partner	<input type="checkbox"/>
Death or illness of another family member	<input type="checkbox"/>
Sudden worsening of health e.g. stroke	<input type="checkbox"/>
Gradual worsening of health or function	<input type="checkbox"/>
Fear, e.g. of criminal behaviour	<input type="checkbox"/>
Something else	<input type="checkbox"/>
Something else	<input type="checkbox"/>

Then go to IB14

Answer these questions only if ‘No’ to Question IB1

IB6. Since your last LILACS NZ interview about a year ago, have you seriously considered moving house? No=0 *(Go to IB19)*; Yes=1 *(continue)*

IB7. Was there any one event that made it important to move?

No=0 (Go to IB9); Yes=1 (continue)

If 'Yes' in question IB7:

IB8. What event was that? Do not read, Do not prompt but put a 1 for each event identified

- Death or illness of spouse or partner
- Death or illness of another family member
- Sudden worsening of health e.g. stroke
- Gradual worsening of health or function
- Fear, e.g. of criminal behaviour
- Something else
- Something else

IB9. Was a decision made about moving?

No, still considering <i>(continue)</i>	Yes, will stay here for now <i>(Go to IB14)</i>	Yes, will move soon but haven't decided where to <i>(Go to IB14)</i>	Yes, will move soon <i>(Go to IB11)</i>	
1	2	3	4	<input type="checkbox"/>

Only those still considering.

IB10. Who was it that *first raised* the issue of a move?

15

- You
- Your child or close family
- Your GP
- Other care providers

- No=0; Yes=1
- Your spouse/partner
 - Neighbour or friend
 - Hospital doctors
 - Someone else

Now go to IB15

IB11. Where will you move to?

- 1 = private dwelling, stand alone house
- 2 = private unit or apartment - independent
- 3 = granny flat unit or apartment on site with family dwelling
- 4 = retirement village - villa or own unit
- 5 = rest home *(Go to IB13)*
- 6 = private hospital *(Go to IB13)*
- 7 = Marae or iwi based housing
- 8 = other.....

If not 'rest home' or 'private hospital' in question IB11:

IB12. Who will you live with most of the time after moving?

- 1 = alone
- 2 = with spouse/partner only
- 3 = with spouse and child/other relative
- 4 = with spouse and non relatives
- 5 = with child (not spouse)
- 6 = with other(s) not spouse or children
- Who?

16

IB13. Why did you choose to move to there?

No=0; Yes=1

- For smaller home
- For larger home
- Better safety and security
- To free up money or equity
- Easier maintenance of house and or gardens
- Closer to shops, post office, or other amenities
- Closer to health services eg. your GP
- Nicer environment eg view, climate, weather
- To be near or with children
- To be near or with other relatives
- To be near or with friends
- To receive the care that I need
- Returning to family/whānau land

Other

15

IB14. Who was it that first raised the issue of a move?

No=0; Yes=1

- | | | | |
|----------------------------|--------------------------|---------------------|--------------------------|
| You | <input type="checkbox"/> | Your spouse/partner | <input type="checkbox"/> |
| Your child or close family | <input type="checkbox"/> | Neighbour or friend | <input type="checkbox"/> |
| Your GP | <input type="checkbox"/> | Hospital doctors | <input type="checkbox"/> |
| Other care providers | <input type="checkbox"/> | Someone else..... | <input type="checkbox"/> |

IB15. Who has contributed to the decision (to stay or move)?

Yes =1 for all that apply

- | | | | |
|----------------------------|--------------------------|---------------------|--------------------------|
| You | <input type="checkbox"/> | Your spouse/partner | <input type="checkbox"/> |
| Your child or close family | <input type="checkbox"/> | Neighbour or friend | <input type="checkbox"/> |
| Your GP | <input type="checkbox"/> | Hospital doctors | <input type="checkbox"/> |
| Other care providers | <input type="checkbox"/> | Someone else..... | <input type="checkbox"/> |

IB16. How much was it your decision (to stay or move)?

17

Wholly my decision	Mostly my decision	About half my decision	Not really my decision	Not at all my decision	<input type="checkbox"/>
1	2	3	4	5	

IB17. How satisfied are you now with the decision (to stay or move)?

12

Very dissatisfied	Dissatisfied	Neither satisfied nor dissatisfied	Satisfied	Very satisfied	<input type="checkbox"/>
5	4	3	2	1	

IB18. Did you consider any of the following as alternatives to moving?

Yes = 1 for all that were considered or received

	<i>Considered</i>	<i>Received</i>
Modifications to the home e.g. ramps or rails		Don't Ask
More support from family		
More support from neighbours &/or friends		
Start home help &/or personal care		
Increase home help &/or personal care		
Better treatment for health conditions, e.g. surgery, therapy or medications		
Something else		
None, no other options considered		

Ask of everyone

IB19. How likely are you to move (again) in the near future?

	Not at all	Somewhat	Moderately	Very	Extremely	
10	1	2	3	4	5	<input type="checkbox"/>

Ask of those not in rest home or private hospital.

IB20. Have there been any renovations or changes to your current home since your last LILACS

NZ interview about a year ago? No=0 *(Go to next section)*; Yes=1 *(continue)*

IB20a. Please look at this list. Tell me what was done

No=0; Yes=1

Redecorated	<input type="checkbox"/>
Added or extended rooms	<input type="checkbox"/>
Improved access e.g. rails, ramps, flooring	<input type="checkbox"/>
Improved heating or insulation	<input type="checkbox"/>
Improved bathroom	<input type="checkbox"/>
Outside garden / fencing improvements	<input type="checkbox"/>
Other? (please describe)	<input type="checkbox"/>

10. Everyday Interests and Activities

We are interested in activities that you spend time doing. First I want to ask you about activities you have done over the last week, that is since last..... (*Interviewer substitute the day of the week*).

Over the past 7 days, how often did you....	0=Never 1=Seeldom (1-2 days) 2=Sometimes (3-4 days) 3=Often (5-7 days)	A. What were these activities?	B. On average, how many hours per day did you engage in these activities? 1 = Less than one hour 2 = 1 - 2 hours 3 = 2 - 4 hours 4 = More than 4 hours
JA1...participate in sitting activities such as reading, watching TV or doing handicraft?	<input type="checkbox"/>		<input type="checkbox"/>
JA2...take a walk outside your home or yard for any reason? For example, for fun or exercise, walking to work, walking the dog etc.?	<input type="checkbox"/>		<input type="checkbox"/>
JA3...engage in light sport or recreational activities such as light gardening e.g. using a ride-on mower, bowling, golf with a cart, shuffleboard, fishing from a boat or pier or similar activities?	<input type="checkbox"/>		<input type="checkbox"/>
JA4...engage in moderate sport and recreational activities such as moderate gardening e.g. using a motor mower, double tennis, ballroom dancing, hunting, ice skating, golf without a cart, softball or other similar activities?	<input type="checkbox"/>		<input type="checkbox"/>
JA5...engage in strenuous sport and recreational activities such as heavy gardening e.g. using a hand mower, jogging, swimming, cycling, singles tennis, aerobic dance, skiing or other similar activities?	<input type="checkbox"/>		<input type="checkbox"/>
JA6...do any exercises specifically to increase muscle strength and endurance, such as lifting weights or push ups etc?	<input type="checkbox"/>		<input type="checkbox"/>

HOUSEHOLD ACTIVITIES AND INTERESTS

Now I'd like to know about household activities you've done over the last 7 days

BC6. During the past 7 days, did you engage in any of the following activities?

(Please answer 'Yes' or 'No' for each item)

No=0; Yes=1

- a. Any light housework, such as dusting or washing dishes
- b. Heavy housework or chores, such as vacuuming, scrubbing floors, washing windows or carrying wood
- c. Home repairs like painting, wall papering, electrical work etc.
- d. Lawn work or yard care, including snow or leaf removal, wood chopping, etc.
- e. Outdoor gardening
- f. Caring for another person, such as children, dependent spouse or another adult.

JA10. What kind of interests have you dropped during the last 12 months?

Have there been any?

0 = No interests dropped (Go to JA11)

1 = One or more interests dropped (list below)

.....

.....

.....

JA10a. Which of these were reasons for dropping some of your interests?

(Code all that apply No=0; Yes=1)

- a. Personal capacity; such as reduced strength or energy, limited mobility, vision impairment, hearing impairment, health or other limitation
- b. Motivation; such as lack of motivation, "it was time to give up", not appropriate or proper to continue
- c. Time use; such as lack of time, doing it takes longer
- d. Security; such as not confident about own limits or abilities, fear of doing things outside the home
- e. Physical environment; such as limited accessibility (e.g. Steps, seating, toilets, parking), or restricted environment (e.g. age limited, car access only)
- f. Social circumstance; such as caring for other/s, loss of partner or friend, relocation
- g. Economic conditions; such as restricted finances or cost
- h. Other

JA11. During the last 4 weeks how often have you

If less than monthly
Occasionally

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	Every day	Every week	Once	Not at all		
a) Spent time on a hobby (including handcrafts)	1	2	3	4	5	<input type="checkbox"/>
c) Visited or been visited by family and friends	1	2	3	4	5	<input type="checkbox"/>
f) Attended meetings of any community/neighbourhood or social groups, such as old people's clubs, lectures or anything like that?	1	2	3	4	5	<input type="checkbox"/>
g) Attended any religious meetings?	1	2	3	4	5	<input type="checkbox"/>
l) Attended a family event	1	2	3	4	5	<input type="checkbox"/>

JA12. Thinking of how you spend your time, would you say, "Most days I....."

Don't have enough to do	Just keep busy enough	Always have more than enough to do	
1	2	3	<input type="checkbox"/>

JA13. How many hours have you spent outside in the *last 4 weeks*?

Thinking about the last 4 weeks, how many hours on a week day (average)

Hours

Hours

Thinking about the last 4 weeks, how many hours on a weekend day (average)

JA14. How much time do you spend by yourself? Are you

Always alone	Often alone	Seldom alone	Never alone	
1	2	3	4	<input type="checkbox"/>

JA14a. And would you say that you:

Always feel lonely	Often feel lonely	Sometimes feel lonely	Never feel lonely	
1	2	3	4	<input type="checkbox"/>

11. Financial Situation

The next couple of questions will ask you about your income and how you manage your money. I will not ask you how MUCH money you have. Remember that any information you give to us will be treated in strictest confidence.

KA6. Thinking of your money situation right now, would you say:

I can't make ends meet	I have just enough to get along on	I am comfortable	
1	2	3	<input type="checkbox"/>

KA7. Thinking of your money situation in the future, would you say, I expect that:

I will not have enough to make ends meet	I will have just enough to get along on	I will be comfortable	
1	2	3	<input type="checkbox"/>

12. Overall Views about growing older

The final questions I want to ask you are about your overall views about growing older and what you have thought about this questionnaire.

MA2. On the whole has growing older been a positive or negative experience for you?

20	Very positive	Mainly positive	Neither positive nor negative	Mainly negative	Very negative	
	1	2	3	4	5	<input type="checkbox"/>

MA1. How much do you agree or disagree with the statement "There is a lot you can do to keep healthy in old age? "

21	Strongly agree	Agree	Unsure	Disagree	Strongly disagree	Don't know	
	1	2	3	4	5	6	<input type="checkbox"/>

Anything that you would like to say; areas of your way of life that have not been covered?

.....

.....

.....

.....

THANK YOU

Thank you for being part of this study. The information you have shared is much appreciated and is very important as it will help us find out how life is now for older New Zealanders.

Interviewer to answer the following

How well do you rate the...	Very poor	Poor	Neither good nor poor	Good	Very good	
a. Reliability of the respondent's responses?	1	2	3	4	5	
b. Participant's understanding of the questions	1	2	3	4	5	
c. Participant's level of interest?	1	2	3	4	5	
d. Participant's level of stamina	1	2	3	4	5	

COMMENTS

COMMENTS continued..

LP1. I would you like to think about this question:

What are the highlights of this stage of life for you?

.....

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.....

- Use only as much space as you require
- Feel free to ask friends or family to help you answer if you'd like to

Please give this page to a LILACS NZ staff member or return it in the envelope provided.

MANY THANKS

