



END OF HAP TREATMENT PATIENT EVALUATION FORM

COUNSELLOR NAME: _____

PATIENT NAME: _____

TRIAL ID: _____

DATE OF DISCHARGE: _____ (DD/MM/YYYY)

1. Reason for discharge (Tick ONLY ONE response)

1.1 Planned discharge

1.2 Drop out (i.e. 3 missed appointments)

1.3 Change in place of residence

1.4 Death of patient

1.5 Referral out of the program (specify to whom and for what reason)

1.6 Refusal to continue with treatment (specify reason for refusal)

1.7 Other (Please specify)



2. What was the overall response of the patient to the treatment? (Tick ONLY ONE response)

2.1 Recovered

2.2 Partly improved

2.3 No change

2.4 Worsened

2.5 Explain your rating in the box below

3. What strategies were the most helpful? (Tick all that apply)

3.1 Activation

3.2 Problem solving

3.3 Dealing with thinking too much

3.4 Relaxation training (breathing exercises)

3.5 Communication strategies

3.6 Dealing with sleep difficulties

3.7 Involving the SO

3.8 Any other (Please give details below)



3.9 Explain why these were the most useful strategies

4. What were the barriers to successfully delivering the treatment? (Tick all that apply)

4.1 Patient did not respond to the treatment

4.2 Patient did not follow through on the treatment expectations, e.g. homework

4.3 Patient did not have time

4.4 Patient was not cooperative

4.5 Family was not cooperative

4.6 Patient could not understand a concept or strategy

4.7 Patient had a physical illness

4.8 Counsellor related issues (Please specify)



4.9 Any other (Please specify)

4.10 Please elaborate your response below