## Appendix 1A
### Anaesthesia and the perioperative period patient experience survey

<table>
<thead>
<tr>
<th>Date of surgery: <strong><strong>/</strong></strong>/____</th>
<th>Today's date: <strong><strong>/</strong></strong>/____</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of anaesthetist:</td>
<td></td>
</tr>
<tr>
<td>Please tell us your Gender: M [ ] F [ ]</td>
<td></td>
</tr>
<tr>
<td>Age [ ] 18-24 [ ] 25-34 [ ] 35-44 [ ] 45-54 [ ] 55-64 [ ] 65-74 [ ] 75 or older [ ]</td>
<td></td>
</tr>
</tbody>
</table>

*For the questions below, please answer yes or no and where indicated choose a rating from 1 to 5, where:*

 diferença = 1 is poor  5 is excellent

1. Did you have pain before surgery? Yes / No (circle)

2. Was your anaesthetist involved in managing your pain before surgery? Yes / No (circle)

If yes, how well do you think we managed your pain?

- 1 [ ]
- 2 [ ]
- 3 [ ]
- 4 [ ]
- 5 [ ]

Are there any comments you would like to make?

2. Did you feel like you had time to ask your anaesthetist questions before your surgery? Yes / No

How well were those questions answered?

- 1 [ ]
- 2 [ ]
- 3 [ ]
- 4 [ ]
- 5 [ ]

Are there any comments you would like to make?

3. Did you understand the information about your anaesthetic that was given to you before your surgery? Yes / No

Are there any comments you would like to make?

4. How useful did you find the information?

- 1 [ ]
- 2 [ ]
- 3 [ ]
- 4 [ ]
- 5 [ ]

Are there any comments you would like to make?
5. Did you feel like your anaesthetist listened to you?  
Yes / No  

Are there any comments you would like to make?

6. Did you feel rushed?  
Yes / No  

Are there any comments you would like to make?

7. Did you feel scared or anxious before your surgery?  
Yes / No  

If yes, how well did your anesthetist manage your fear and anxiety?  
1 2 3 4 5  
Comments:

8. Did your anesthetist explain to you how you might feel after the surgery?  
Yes / No  

Comments:

9. Did you feel nauseated and/or vomit immediately after the surgery?  
Yes / No  

If yes, how well was it treated?  
1 2 3 4 5  
Comments:
10. Were you in pain after the operation?  
Yes / No
If yes, how effective was your pain treatment?  
1 2 3 4 5
Comments:

11. Were you cold or shivering after the surgery?  
Yes / No
If yes, how well was it managed?  
1 2 3 4 5
Comments:

12. If you had a positive experience, please tell us about it.

13. If you had a negative experience, please tell us about it.

14. Do you have any suggestions about how your care could have been improved?