

## Patient experience questionnaire content

Regarding **Small bowel MRI** (In this scan you were given a large drink beforehand. The scan takes about half an hour and you lie down in a tube (MRI scanner) sometimes with headphones on)

**Have you had this test?**

Yes

No

Not sure

☐
☐
☐

***If you have not had this test please skip this section***

**How acceptable did you find this test?**

Not at all acceptable

Slightly acceptable

Fairly acceptable

Very acceptable

I did not have this test

☐
☐
☐
☐
☐

**Overall, which of the following was the **LEAST** acceptable aspect (or worst bit) of each of this test?  
Please tick just **ONE** option.**

Claustrophobia

Lying still

Lots of breath  
holding

Noise

The time it took

☐
☐
☐
☐
☐

The need to have  
injections

How uncomfortable  
it was

Drinking the fluid  
before the test

Fasting before the  
test

Having to wait for  
the result

☐
☐
☐
☐
☐

It was all fine

☐

Other, please specify\_\_\_\_\_

**Please indicate below how long you felt it took before you were fully recovered.**

Immediately

Up to 30 minutes

Up to 2 hours

Up to 4 hours

Up to 6 hours

☐
☐
☐
☐
☐

Up to 1 day

Up to 2 days

Up to 3 days

A week

☐
☐
☐
☐

**Would you agree to have this test again if necessary?**

Yes

No

Not sure

☐
☐
☐

**THINKING ABOUT THE SMALL BOWEL MRI THAT YOU HAD** (In this scan you were given a large drink beforehand. The scan takes about half an hour and you lie down in a tube (MRI scanner) sometimes with headphones on)

**For each word or statement below, please tick (☑) the box on the scale which best describes your experience of the test. Please begin by looking at the example below.**

## EXAMPLE

FOR EXAMPLE: If you felt that **time went slowly** you might tick the scale like this

[illegible]

Or if you felt that **time went neither slowly nor quickly** you might tick the scale like this

Time went slowly	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Time went quickly
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**Now please answer the following**

[illegible][illegible][illegible]

I was not interested	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	I was interested

Loss of modesty	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	No loss of modesty

The noise of the scanner unbearable	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	The noise of the scanner was fine
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[illegible]

Agitated	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Calm
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Not confident in staff	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Confident in staff

Tired afterwards	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Not tired afterwards

The need to repeatedly hold my breath was unbearable	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	The need to repeatedly hold my breath was fine
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[illegible]

[illegible]

Regarding **Small bowel ultrasound** (In this scan you were NOT given a large drink beforehand. Afterwards the doctor puts jelly on your abdomen and images are taken using a probe on the skin)

**Have you had this test?**

Yes

No

Not sure

☐
☐
☐

***If you have not had this test please skip this section***

**How acceptable did you find this test?**

Not at all acceptable

Slightly acceptable

Fairly acceptable

Very acceptable

I did not have this test

☐
☐
☐
☐
☐

**Overall, which of the following was the LEAST acceptable aspect (or worst bit) of each of this test?  
Please tick just ONE option.**

Lying still

Lots of breath  
holding

Abdominal  
compression

How uncomfortable  
it was

The time it took

☐
☐
☐
☐
☐

Fasting before the  
test

It was all fine

Having to wait for  
the result

☐
☐
☐

Other, please specify\_\_\_\_\_

**Please indicate below how long you felt it took before you were fully recovered.**

Immediately

Up to 30 minutes

Up to 2 hours

Up to 4 hours

Up to 6 hours

☐
☐
☐
☐
☐

Up to 1 day

Up to 2 days

Up to 3 days

A week

☐
☐
☐
☐

**Would you agree to have this test again if necessary?**

Yes

No

Not sure

☐
☐
☐

**THINKING ABOUT THE SMALL BOWEL ULTRASOUND SCAN THAT YOU HAD** (In this scan you were NOT given a large drink beforehand. Afterwards the doctor puts jelly on your abdomen and images are taken using a probe on the skin)

**For each word or statement below, please tick (☑) the box on the scale which best describes your experience of the test. Please begin by looking at the example below.**

## EXAMPLE

FOR EXAMPLE: If you felt that **time went slowly** you might tick the scale like this

[illegible]

Or if you felt that **time went neither slowly nor quickly** you might tick the scale like this

Time went slowly	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Time went quickly
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**Now please answer the following**

[illegible][illegible][illegible][illegible][illegible]

The pressure of the probe was unbearable	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	The pressure of the probe was fine
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[illegible][illegible][illegible][illegible]

The need to repeatedly hold my breath was unbearable	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	The need to repeatedly hold my breath was fine
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[illegible]

[illegible]

If you had to have **JUST ONE** of the tests small bowel MRI or small bowel ultrasound (US) again which one would you prefer? Please circle or underline the one you would choose.

Small bowel MRI

OR

Small bowel US

Thinking about the investigations/ tests you have had - how **IMPORTANT** were the following things to you?

	Not at all important	A little bit important	Moderately important	Very important	Extremely important
The <b>number</b> of tests you needed to have before you knew what your full <b>diagnosis</b> was	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If there was more than one treatment, the <b>number</b> of tests you needed before doctors could choose the <b>best treatment</b> to help your condition/ cure your symptoms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>How long</b> you had to wait to get a full <b>diagnosis</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If there was more than one treatment, <b>how long</b> you had to wait because of tests before doctors could choose the <b>best treatment</b> to help your condition/ cure your symptoms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How accurate the result of the test was (i.e. how good the test was in getting the full and correct diagnosis)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How long the test took (for example 10 mins or 1 hour)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How claustrophobic the test was	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How uncomfortable the test was	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If you had to hold your breath lots of times for the test	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If you had to lie very still for the test	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The need to prepare for the test by fasting (not eating)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



How embarrassing it was to do the test	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How painful it was to do the test	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How noisy the test was	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Whether you needed to be sedated (with drugs to make you sleepy) during the test	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How sore it made you after the test	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How much privacy you had during the test	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How tired you felt after the test	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Whether you suffered nausea/ vomiting after the test	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Whether you felt faint or dizzy after the test	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How frightening it was to do the test	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Whether you were exposed to X-Ray radiation as a result of having the test	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If you had to drink a large volume of liquid before the test	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If pressure was applied to your abdomen by the person during the test	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Being able to ask about the results straight after the test	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>