APPENDIX 12: SENSE OF CONTROL

Thank you for taking part in the study.

We would appreciate your opinion. Please give your honest views.

**Your feedback will be anonymous.**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Yes Definitely | Yes to some extent | Not Really | Definitely Not  | Does not apply |
| **As a result of being involved in this study:** |  |  |  |  |  |
| 1. Do you feel you have a better understanding of your condition?
 |  |  |  |  |  |
| 1. Do you have a better understanding of what the medication is for?
 |  |  |  |  |  |
| 1. Do you feel more confident in using the medication?
 |  |  |  |  |  |
| 1. Do you feel more confident about managing an exacerbation?
 |  |  |  |  |  |
| 1. Do you feel more able to manage your condition on a day to day basis?
 |  |  |  |  |  |
| 1. Do you know *your* goals for treatment?
 |  |  |  |  |  |
| 1. Do you feel more able to achieve *your* goals for treatment?
 |  |  |  |  |  |
| 1. Do you feel more able to take the role you want in your own care?
 |  |  |  |  |  |
| 1. Comments
 |  |

**THANK YOU VERY MUCH FOR TAKING THE TIME AND TROUBLE TO COMPLETE THIS QUESTIONNAIRE.**