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| **India Mkt Asmt\_COAGULATION POC** | | | | | | | | | | **2** | | | **3** | | **0** | | **6** | | | **9** | | **8** | | | **4** | | | **6** | | **0** | | | **2** | | |  | | |  | | |  | | |  | | |  | |  |
|  | | | | | | | | | | Col - 31-38 | | | | | | | | | | | | | | | | | | | | | | | | | | Col - 1-7 | | | | | | | | | | | | | | |
| **SP – ZONE** | | | | | | | | | | **SP NO.** | | | | | | | **G.C NO.** | | | | | | | | **INTERVIEW NO.** | | | | | | | | | **WEEK NO.** | | | | | | | | | **MONTH NO.** | | | | | | | |
| **N** | **E** | **W** | | | | **S** | | **C** | |  | |  | | |  | |  | |  | | |  | | |  | | |  | | |  | | |  | | |  | | |  | | |  | | |  | | |  | |
| Col – 15 | | | | | | | | | | Col – 16-18 | | | | | | | Col – 19-21 | | | | | | | | Col – 22-24 | | | | | | | | | Col – 25-27 | | | | | | | | | Col – 28-29 | | | | | | | |
| **RESPONDENTS HOUSE/OFFICE ADDRESS–COMPLETE ADDRESS IS MUST (Write in CAPITAL letters)** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **DOCTOR’s FIRST NAME\*/** | | | | | | | |  | | | | | | | | | | | | | **SUR NAME: \*** | | | | | | | | | | |  | | | | | | | | | | | | | | |  | | | |
| **Doctor’s Qualification (as in Visiting Card/ board in clinic)** | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | |
| **Hospital/ Clinic name\*/** | | | | | | | |  | | | | | | | | | | | | | **FLOOR No.** | | | | | | | | | | |  | | | | | | | | | | | | | | |  | | | |
| **Hospital/ Clinic Address (Line 1)/** | | | | | | | |  | | | | | | | | | | | | | **STREET / ROAD NAME** | | | | | | | | | | |  | | | | | | | | | | | | | | |  | | | |
| **Hospital/ Clinic Address (Line 2)/** | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | |
| **AREA** | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | |
| **CITY\*** | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | |
| **PINCODE** | | | | | | | |  |  | |  | | |  |  |  | | **MOBILE No. (Mandatory)** | | | | | | | |  | |  | |  | |  | | |  | |  | |  | |  | |  | |  | |  | | | |
| **PHONE No. (Res)** | | | | | | | |  | |  |  | | |  |  |  | |  | | |  |  | |  | | |  | | | | | | | | | | | | | | | | | | | | | |  | |
| **PHONE No. (Off)** | | | | | | | |  | |  |  | | |  |  |  | |  | | |  |  | |  | | | **Extn.** | | | |  | |  | | |  | |  | |  | | | | | | | | |  | |
| **e-mail ID** | | |  | |  | |  |  | |  |  | | |  |  |  | |  | | |  |  | |  | | |  | |  | |  | |  | | |  | |  | |  | |  | |  | |  | | |  | |
| **FIELD CONTROL INFORMATION** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **FIELD CONTROL INFORMATION** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **BASE CENTER** | | | | **CODE** | | | | **BASE CENTER** | | | | | | **CODE** | | **BASE CENTER** | | | | | | | **CODE** | | | | | | **BASE CENTER** | | | | | | | | **CODE** | | | | **BASE CENTER** | | | | | | | | **CODE** | |
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|  | | | |  | | | | **Jaipur** | | | | | | **012** | | **Guwahati** | | | | | | | **013** | | | | | | **Indore** | | | | | | | | **014** | | | |  | | | | | | | |  | |
| **Cochin** | | | | **016** | | | | **Varanasi** | | | | | | **017** | | **Nagpur** | | | | | | | **018** | | | | | | **Bhubaneshwar** | | | | | | | | **019** | | | | **Vizag** | | | | | | | | **020** | |

|  |
| --- |
| Good \_\_\_\_\_\_\_\_, (Morning/Afternoon/Evening) Doctor this survey is being conducted by Ipsos, a premier market research and consulting firm in India. We conduct surveys from time to time on wide range of subjects and seek opinion from doctors like yourself to understand their views and opinion.  **We are presently carrying out a study for understanding the market for warfarin treatment and need for PT/INR monitoring.**  Your views and opinion are very valuable to us. All the information that you provide to us would be kept confidential; please feel free to be candid when you offer your opinions. The study comprises of an online survey that will last for approximately 15 minutes. Please note that we are not trying to sell any products or services and are purely interested in your opinion.  IPSOS is committed to supply any product safety information resulting from the market research activities as well as carry out all the reporting requirements of pharmaco-vigilance which then has to be reported directly to pharmaco-vigilance department of the research sponsor company |
|  |

**SCREENER**

1. Doctor, could you please tell us where is your practice location?

|  |  |  |
| --- | --- | --- |
| **Location** | **Select** | **Routing** |
| Mumbai | 01 | **CONTINUE** |
| Kolkata | 02 | **CONTINUE** |
| Bangalore | 03 | **CONTINUE** |
| Delhi | 04 | **CONTINUE** |
| Chennai | 05 | **CONTINUE** |
| Others | 09 | TERMINATE |

1. Please, tell us which of this best describes your primary practice specialization?

|  |  |  |
| --- | --- | --- |
| **Practice type** | **Code** | **Routing** |
| Private practice | 01 | **CONTINUE** |
| Public practice | 02 | TERMINATE |

1. Please, tell us which of this best describes your primary practice specialization?

|  |  |  |
| --- | --- | --- |
| **Specialty** | **Select** | **Routing** |
| Consulting Physicians | **01** | **CONTINUE** |
| Clinical Cardiologist (MD- DM) | **02** | **CONTINUE** |
| Interventional cardiologist (MD-DM) performs intervention | **03** | **CONTINUE** |
| Cardiothoracic Surgeon | **04** | **CONTINUE** |
| Others | **05** | TERMINATE |

1. Doctor could you please tell me for **how many years you have been practicing post residency (in years)**? [SA] **CAPTURE IN NUMBER** **RANGE: 5–45 years, else terminate.**

|  |
| --- |
| **Years of experience** |
|  |

1. Doctor, could you please tell, what is the total number of Atrial Fibrillation patients consulted/treated by you on an average in a month, considering both new & follow-up?

SCREENING CRITERIA: CONTINUE IF TOTAL PATIENT LOAD IS >/= 30 IN A Month

|  |
| --- |
|  |

**S6**. Doctor, which of the following treatment do you recommend to your Atrial fibrillation patients?

|  |  |  |
| --- | --- | --- |
| 1 | Warfarin | CONTINUE ONLY IF OPTION 1 IS SELECTED, ELSE TERMINATE |
| 2 | NOACs |
| 3 | Others (Please specify) |

**S7.** On an average how many patients do you prescribe warfarin in a month?

|  |  |
| --- | --- |
| **Avg. no of patients prescribed Warfarin per month** |  |

SCREENING CRITERIA: CONTINUE IF PATIENT PRESCRIBED WARFARIN IS >/= 10 IN A Month

|  |
| --- |
| **MAIN QUESTIONNAIRE** |

*Doctor, this section would focus on your current practice setting*

Q1. Doctor, how many patients do you treat/consult on an **average in a month** across all indications? *Please include both new vs follow-up patients*

**SCRIPTER INSTRUCTION: ALLOW NUMERIC VALUE**

|  |
| --- |
|  |

**Q1a.** Of the total patient load, what would be the proportion split between New Vs Follow-up patients**:**

|  |  |
| --- | --- |
| **Patient Type** | **Patient proportion by Type** |
| New patients |  |
| Follow up patients |  |
| **TOTAL** | **SUM SHOULD BE 100%** |

Q2. Doctor, in which of the following **Conditions/ indications do you prescribe anticoagulants**?

**CONTINUE ONLY IF OPTION 1 OR 2 IS SELECTED**

|  |  |  |
| --- | --- | --- |
|  | **INDICATIONS (RANDOMISE)** | **MULTIPLE SELECT** |
| R1 | Atrial Fibrillation (Vascular) | 1 |
| R2 | Atrial Fibrillation (Non-vascular) | 2 |
| R3 | Mitral Stenosis | 3 |
| R4 | AHV (Artificial Heart Valves) | 4 |
| R5 | Deep Venous Thrombosis | 5 |
| R6 | Pulmonary Embolism | 6 |
| R7 | Post-Op recovery | 7 |
| R8 | Other (Please specify \_\_\_\_\_\_\_\_)  **ANCHOR AT THE BOTTOM** | 8 |
| R9 | Other (Please specify \_\_\_\_\_\_\_\_)  **ANCHOR AT THE BOTTOM** | 9 |

**Q3.** Doctor, on an average how many patients with the following condition do you consult / treat in a month?

**SHOW ALL THE INDICATIONS SELECTED IN Q2**

**ALLOW NUMERIC VALUE**

**TOTAL SHOULD NOT BE MORE THAN RESPONSE IN Q1**

|  |  |  |
| --- | --- | --- |
|  | **INDICATIONS** | **No of patients across indications per month** |
| R1 | Atrial Fibrillation (Vascular) |  |
| R2 | Atrial Fibrillation (Non-vascular) |  |
| R3 | Mitral Stenosis |  |
| R4 | AHV (Artificial Heart Valves) |  |
| R5 | Deep Venous Thrombosis |  |
| R6 | Pulmonary Embolism |  |
| R7 | Post-Op recovery |  |
| R8 | Other (Please specify \_\_\_\_\_\_\_\_)  **ANCHOR AT THE BOTTOM** |  |
| R9 | Other (Please specify \_\_\_\_\_\_\_\_)  **ANCHOR AT THE BOTTOM** |  |

**Q4.** Out of total patients that you see across all the indications, what is the proportion of patients to whom you recommend anticoagulant therapy?

|  |  |
| --- | --- |
| **% of patients on anti-coagulation therapy** |  |

Q5. Out of all patients to whom you recommend anti-coagulant therapy, what is the proportion of patients who are recommended **long-term anticoagulant therapy** *i.e for pro-longed period of time*?

|  |  |
| --- | --- |
| **% of patients on long term anti-coagulation therapy** |  |

Q6. For patient who are on **long term anti-coagulation therapy**, what is the proportion of patients on the following anti-coagulant therapy?

|  |  |  |
| --- | --- | --- |
| **SPLIT OF PATIENTS ON ANTIOAGULATION THERAPY** | **% patients on long term anti-coagulation therapy** |  |
| **Only Warfarin** |  | **TERMINATE IF RESPONSE IS <1%** |
| **VITAMIN K ANTAGONIST** other than Warfarin |  |  |
| **Only NOACs** |  |  |
| **TOTAL** | **100%** |  |

Q7. Doctor, considering 100 patients on **long-term NOACs**, what is proportion of patients across the health indications?

SHOULD NOT BE ASKED TO RESPONDENTS WHO CODE <1% FOR ONLY NOAC’s IN Q6

**Please ensure that the proportions allocated across all therapy should add up to 100%**

**SCRIPTER INSTRUCTION: ASK ONLY FOR INDICATIONS MENTIONED IN ‘Q2’.**

|  |  |  |
| --- | --- | --- |
|  | **INDICATIONS** | **% patients on long-term NOACs** |
| R1 | Atrial Fibrillation (Vascular) |  |
| R2 | Atrial Fibrillation (Non-vascular) |  |
| R3 | Mitral Stenosis |  |
| R4 | AHV (Artificial Heart Valves) |  |
| R5 | Deep Venous Thrombosis |  |
| R6 | Pulmonary Embolism |  |
| R7 | Post-Op recovery |  |
| R8 | Other (Please specify \_\_\_\_\_\_\_\_)  **ANCHOR AT THE BOTTOM** |  |
| R9 | Other (Please specify \_\_\_\_\_\_\_\_)  **ANCHOR AT THE BOTTOM** |  |
|  | Total | **100%** |

Q8. Doctor, considering 100 patients on long-term **Warfarin**, what is proportion of patients across the health indications?

**Please ensure that the proportions allocated across all therapy should add up to 100%**

**SCRIPTER INSTRUCTION: ASK ONLY FOR INDICATIONS MENTIONED IN ‘Q2’.**

|  |  |  |
| --- | --- | --- |
|  | **INDICATIONS** | **% patients on long-term WARFARIN** |
| R1 | Atrial Fibrillation (Vascular) |  |
| R2 | Atrial Fibrillation (Non-vascular) |  |
| R3 | Mitral Stenosis |  |
| R4 | AHV (Artificial Heart Valves) |  |
| R5 | Deep Venous Thrombosis |  |
| R6 | Pulmonary Embolism |  |
| R7 | Post-Op recovery |  |
| R8 | Other (Please specify \_\_\_\_\_\_\_\_)  **ANCHOR AT THE BOTTOM** |  |
| R9 | Other (Please specify \_\_\_\_\_\_\_\_)  **ANCHOR AT THE BOTTOM** |  |
|  | **TOTAL** | **100%** |

|  |
| --- |
| **PT-INR MONITORING** |

Doctor, this section would focus on the long-term Warfarin Therapy and PT/INR Monitoring

Q9. What are the challenges that you encounter while treating/managing patients on long-term Warfarin therapy?

|  |  |  |
| --- | --- | --- |
|  | **CHALLENGES WITH RESPECT TO WARFARIN THERAPY** | **MULTIPLE SELECT** |
| R1 | Bleeding | 1 |
| R2 | significant haemorrhage | 2 |
| R3 | Continuous PT-INR monitoring | 3 |
| R4 | Drug-drug interaction (Warfarin with other drugs) | 4 |
| R5 | Drug-food interaction (Food hindering INR monitoring) | 5 |
| R98 | Other (Please specify \_\_\_\_\_\_\_\_) | 6 |
| R99 | Other (Please specify \_\_\_\_\_\_\_\_) | 7 |

Q10. For patients who are just started on the long-term warfarin treatment, what is the frequency of follow-up consultation with you?

|  |  |
| --- | --- |
| **Frequency** | **Single Select** |
| Twice a week | **1** |
| Once a week | **2** |
| 2-3 times a month | 3 |
| Once a month | 4 |
| Once in 2 months | 5 |
| Once in 3 months | 6 |

Q11. How does the frequency of follow-up consultation changes once the dosage of Warfarin is fixed?

|  |  |
| --- | --- |
| **Frequency** | **Single Select** |
| Once a month | **1** |
| Once in 2-3 months | **2** |
| Once or twice in 6 months | 3 |
| Once in a year | 4 |

Q12. Doctor, do you recommend PT-INR testing to you patients on Warfarin Therapy?

|  |  |
| --- | --- |
| **Recommendation** | **SINGLE SELECT** |
| Yes, To all patients on warfarin | **1** |
| Yes, only to patients on Long-term warfarin therapy | **2** |
| No, None of the patients on Warfarin | 3 |

IF SELECTED 1 OR 2, ASK Q13.

Q13. Doctor, what is the proportion of patients on Warfarin therapy to whom you recommend PT-INR test?

|  |  |
| --- | --- |
|  | **% recommendation for PT-INR** |
| % patients on short term warfarin therapy  **ASK IF SELECTED 1 in Q12** |  |
| % patients on Long-term warfarin therapy  **ASK IF SELECTED 1 & 2 in Q12** |  |

Q14. Have you ever recommended PT-INR test for Patients on NOACs therapy?

|  |  |
| --- | --- |
| **Recommendation** | **SINGLE SELCT** |
| Yes, To all patients on NOACs | **1** |
| Yes, only to patients on Long-term NOACs | **2** |
| No, None of the patients on NOACs | 3 |

IF YES IN Q14, ASK Q14A

Q14a. What proportion of patients on NOACs are recommended PT-INR test?

|  |  |
| --- | --- |
| % of patients on NOACs |  |

Q15. Out of all the patients who are recommended PT-INR testing, what is the proportion of patients recommended PT-INR monitoring at the following timelines?

|  |  |
| --- | --- |
| **Frequency of PT-INR monitoring** | **% Patients recommended PT-INT test on the following frequency** |
| Daily Monitoring |  |
| 2-3 times in a week |  |
| Once a week |  |
| Once a Month |  |
| Once in 2-3 months |  |
| **TOTAL** | **100%** |

Q16. Doctor, what is the proportion of patients undertaking PT-INR testing across different places?

|  |  |
| --- | --- |
| **Place of Testing** | **% patients on warfarin** |
| Private Labs |  |
| Hospitals |  |
| Home (POC device) |  |
| Other (Please specify\_\_\_\_\_) |  |
| TOTAL | 100% |

Q17. Doctor, across all indications where anti-coagulation therapy is recommended what is the average number of the patients undertaking PT-INR monitoring regularly?

**SCRIPTER INSTRUCTION: ASK ONLY FOR INDICATIONS MENTIONED IN ‘Q2’.**

|  |  |  |
| --- | --- | --- |
|  | **INDICATIONS** | **No of patients undergoing PT-INR monitoring per month** |
| R1 | Atrial Fibrillation (Vascular) |  |
| R2 | Atrial Fibrillation (Non-vascular) |  |
| R3 | Mitral Stenosis |  |
| R4 | AHV (Artificial Heart Valves) |  |
| R5 | Deep Venous Thrombosis |  |
| R6 | Pulmonary Embolism |  |
| R7 | Post-Op recovery |  |
| R8 | Other (Please specify \_\_\_\_\_\_\_\_)  **ANCHOR AT THE BOTTOM** |  |
| R9 | Other (Please specify \_\_\_\_\_\_\_\_)  **ANCHOR AT THE BOTTOM** |  |

Q18. Doctor, are you aware of any PT-INR self-monitoring POC device?

|  |  |
| --- | --- |
|  | **SINGLE SELCECT** |
| Yes | **1** |
| No | 2 |

**IF YES, ASK THE FOLLOWING QUESTIONS Q19 to Q23:**

Q19. Doctor, can you please name some brands of PT-INR self-monitoring device that you are aware of? **OPEN END**

|  |
| --- |
|  |
|  |
|  |
|  |

Q20. Doctor, do you use PT-INR self-monitoring device at your clinic?

|  |  |
| --- | --- |
|  | **SINGLE SELECT** |
| Yes | **1** |
| No | 2 |

Q21. Doctor, of the total patients who need regular PT-INR monitoring, what percentage of patients own a self-monitoring PT-INR device at their home?

|  |  |
| --- | --- |
| **% of patients who own self-monitoring PT-INR device at their home** |  |

Q22. Doctor, currently what percentage of patients do you recommend self-monitoring PT-INR POC device at home?

|  |  |
| --- | --- |
| **% of patients recommended self-monitoring PT-INR POC at home** |  |

Q22 A. Of the patients recommended, what % of patients purchased PT-INR POC device?

|  |  |
| --- | --- |
| **% of patients who purchased PT-INR POC device** |  |

Q23. How does this recommendation of PT-INR POC Device differ based on the need of patients?

|  |  |
| --- | --- |
| **Frequency of PT-INR monitoring** | **% Patients recommended PT-INR test on the following frequency** |
| Daily Monitoring |  |
| 2-3 times in a week |  |
| Once a week |  |
| Once a Month |  |
| Once in 2-3 months |  |
| **TOTAL** | **100%** |

|  |
| --- |
| **CONCEPT TESTING (ASK ALL)** |

**Doctor, now we will be showing you a concept of device for self-monitoring PT-INR, please share your honest opinion with us.**



24. Doctor, what is your overall opinion the concept shown.

*Please rate from 1 to 10, with 10 being Extremely liked to 1 being Not at all liked.*

***SINGLE SELECT***

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| Not at all liked |  |  |  | Neutral |  |  |  |  | Extremely liked |

24 a. What did you specifically like about the concept?

|  |
| --- |
|  |

24 b. What did you specifically dis-like about the concept?

|  |
| --- |
|  |

25. Considering the importance of PT-INR monitoring, how relevant do you think is the concept for Warfarin therapy? ***SINGLE SELECT***

*Please rate from 1 to 10, with 10 being Extremely relevant to 1 being Not at all relevant.*

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| Not at all relevant |  |  |  | Neutral |  |  |  |  | Very Relevant |

Q26. What is your opinion on effectiveness of self-monitoring POC device shown in the concept?

***SINGLE SELECT***

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| Not at all effective |  |  |  | Neutral |  |  |  |  | Very Effective |

Q27. How likely are you to recommend these devices to the patients of warfarin therapy in future?

***SINGLE SELECT***

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| Not at all likely |  |  |  | Neutral |  |  |  |  | Very Likely |

Q28. Doctor, how likely are you going to use this device in your clinic? *Kindly rate in the scale of 1-10, with 10 being most likely to 1 being not at all.*

***SINGLE SELECT***

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| Not at all likely |  |  |  | Neutral |  |  |  |  | Very Likely |

Q29. Doctor, how likely will you recommend this device to your patients on long term Warfarin therapy? *Kindly rate in the scale of 1-10, with 10 being most likely to 1 being not at all.*

***SINGLE SELECT***

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| Not at all likely |  |  |  | Neutral |  |  |  |  | Very Likely |

Q30. Doctor, as per you opinion what should be the ideal price point for this device?

|  |  |
| --- | --- |
| **Price** | **Single Select** |
| <5000 INR | 1 |
| 5,001-10,000 INR | 2 |
| 10,001-15,000 INR | 3 |
| 15,001 -20,000 INR | 4 |
| 20,000 – 25,000 INR | 5 |
| <25,000 INR | 6 |

Q30. A. According to you, what should be the ideal cost of each testing via this POC device? Please select the ideal price point for a box of **10 strips**.

|  |  |
| --- | --- |
| **Price** | **Single Select** |
| <500 INR | 1 |
| 501-1,000 INR | 2 |
| 1,001-2,000 INR | 3 |
| 2,001-3,000 INR | 4 |
| 3,001 - 4,000 INR | 5 |
| <4,000 INR | 6 |

Q 31 Doctor as per your opinion what are the benefits for using of this PT-INR self-monitoring device?

|  |  |
| --- | --- |
| **BENEFITS OF PT-INR Self-monitoring DEVICE** | **MULTIPLE SELECT** |
| Allows timely monitoring for PT-INR | 1 |
| Small, light and easily portable device | 2 |
| Reduces lab visits | 3 |
| Ease of monitoring | 4 |
| Beneficial to bed ridden and elderly patients. | 5 |
| Others (Please specify \_\_\_\_\_\_) | 6 |

Q 32 Doctor as per your opinion what are the challenges for the usage of this PT\_INR self-monitoring device?

|  |  |
| --- | --- |
| **Challenges** | **MULTIPLE SELECT** |
| Not trustworthy like diagnostic lab | 1 |
| Need timely calibration | 2 |
| Patients needs prior training for using this device | 3 |
| Affordability issue | 4 |
| Lack of awareness about the use and efficacy of device | 5 |
| Others (Please specify \_\_\_\_\_\_) | 6 |

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| **THANK YOU FOR YOUR TIME** |