APPENDIX G

QUARTERLY TELEPHONE INSTRUMENT

Referral Number

Participant Name:_____

Address: _____

Phone Number: _____

Independent Living and Mobility Program

Quarterly Follow-up

Assessor – *Print your name with credentials and the date that the interview was completed.*

Name and credentials:_____

Date of interview:_____

● Introduction

My name is _____, and I am calling in regard to the Independent Living and Mobility Program. I am calling to get updated information regarding your current Exercise Routine and to see how you have been doing since we last contacted you. The interview will take approximately 5-15 minutes. Is this a good time?

If not, schedule a time to call the participant back to complete phone screen.

● General Questions

A. Since we last talked, have you seen your primary care doctor?..... ☐
No..... ☐
Yes

B. Since we last talked, have you had any new symptoms or been diagnosed with any new conditions?..... ☐
No..... ☐
Yes

	Condition	Date of Diagnosis/ 1st Symptom	Date of most recent Symptom	Is Condition treated by a doctor?	Is Condition Controlled/ Stable?	Treatment
1				☐No ☐Yes	☐No ☐Yes	
2				☐No ☐Yes	☐No ☐Yes	
3				☐No ☐Yes	☐No ☐Yes	

C. Since we last talked, have you started any new medications?..... ☐
No..... ☐
Yes

	Medication Name	Dosage	Frequency	If PRN, indicate how often used?	Reason for taking
1					
2					
3					

D. Since we last talked, have you discontinued any medications?..... ☐
No..... ☐
Yes

	Medication Name	Reason stopped taking
1		
2		

3		

E. Since we last talked, have you had any changes in any of your medication dosages or how often you take them?..... ☐
No..... ☐
Yes

	Medication Name	Dosage	Frequency	If PRN, indicate how often used?
1				
2				
3				

F. Since we last talked, have you had any new treatments prescribed or recommended?..... ☐
No..... ☐
Yes

If Yes, What type of treatment? ☐ Physical Therapy____☐
Occupational Therapy
☐ Other:

Why? _____

G. Since we last talked, have you had any Hospital Admissions, Emergency Room visits or Surgery?.....☐
No ☐ Yes

If Yes, indicate number of times: _____ times and supply details below:

	Reason for Hospital Admission/ Emergency Room visit/ Surgery	Date (month/year)	Type of Surgery &/or Treatment received	Current Status
1				
2				
3				

H. Since we last talked, have you changed your primary care doctor?...☐
No.....☐
Yes

If Yes, Why?_____

New Physician's name:_____Phone number:_____

City:_____State_____Street address:_____

Specialty:_____

● Exercise History

The next questions refer to your exercise routine.

I. Have you been filling in the Exercise Progress Chart on a daily or weekly basis?.....☐
No.....☐
Yes

If Yes, you may want to refer to it as you answer the next few questions

J. In the past 7 days have you participated in any exercise?.....☐
No.....☐
Yes

If Yes, How many days (in the past week)? ☐1 day ☐2 days ☐3 days ☐4 days
☐5 days ☐6 days ☐7 days

How many hours per day?
☐<1 hr but more than 30 min ☐1 hour ☐>1 hr but less than 2 hr ☐2 hours
☐>2 hr but less than 3 hr ☐3 hours ☐>3 hours ☐
Other:_____

What type of exercise?
☐Endurance= increase breathing/heart rate (brisk walk, stairs, swim, aerobics, jog, cycle, tennis, dance, shovel, ski, hike, rake/row lawn, mop/scrub floor)
☐Strength= build muscles (weights, chair stands, arm/leg raises, hip/knee/shoulder flexion/extension, sit-ups, push-ups)

☐ Balance= improve/maintain balance (heel-to-toe walk, stand on one foot, strength exercises using one hand/one finger for holding on or not holding on)
☐ Flexibility= stretching to improve freedom of movement (arm, shoulder, wrist, leg, ankle, hip and neck stretching)

K. Has this been your typical routine over the past 3 months?..... ☐
No..... ☐
Yes

If No, How often do you usually exercise? ☐ 1 day/wk ☐ 2 days/wk ☐ 3 days/wk ☐ 4 days/wk
☐ 5 days/wk ☐ 6 days/wk ☐ 7 days/wk

How many hours per day?
☐ <1 hr but more than 30 min ☐ 1 hour ☐ >1 hr but less than 2 hr ☐ 2 hours
☐ >2 hr but less than 3 hr ☐ 3 hours ☐ >3 hours ☐
Other:_____

What type of exercise?
☐ Endurance= increase breathing/heart rate (brisk walk, stairs, swim, aerobics, jog, cycle, tennis, dance, shovel, ski, hike, rake/row lawn, mop/scrub floor)
☐ Strength= build muscles (weights, chair stands, arm/leg raises, hip/knee/shoulder flexion/extension, sit-ups, push-ups)
☐ Balance= improve/maintain balance (heel-to-toe walk, stand on one foot, strength exercises using one hand/one finger for holding on or not holding on)
☐ Flexibility= stretching to improve freedom of movement (arm, shoulder, wrist, leg, ankle, hip and neck stretching)

Why have you not been following your typical exercise routine?

L. Would you like for us to mail you some more Weekly Schedules for your Exercise Progress Chart?..... ☐
No..... ☐
Yes

● Falls History

The next questions refer to any fall that you may have experienced in since we last contacted you.

M. Since our last call, have you had one or more episodes of fainting, falling or dropping to the ground, passing out or have you lost your balance or tripped over something that resulted in falling or dropping to the ground?.....☐
No.....☐
Yes

If Yes, How many times did this happen?_____

Do you fill out the Fall Journal whenever you have a fall? ....☐No ☐Yes
If Yes, you may want to refer to it as you answer the next few questions

What time of day did you fall? .....☐Day ☐
Eve

Morn/Day ☐5:01AM-9:00AM ☐9:01AM-12:00PM ☐12:01PM-4:00PM
Eve/Noc ☐5:01PM-7:00PM ☐7:01PM-10:00AM ☐10:01AM-5:00AM

Did you sustain any injuries? .....☐No ☐Yes
Did you require Medical Attention? .....☐No ☐Yes
☐Doctor Visit ☐Hospital Admission ☐Emergency Room Visit

What were you doing when you fell?_____

Were you at home when you fell? .....☐No ☐Yes
If Yes, Where? ☐Bathroom ☐Kitchen ☐Stairs ☐Entryway ☐Other:_____
If No, Where? ☐Store/Business ☐Parking Lot/Street_____☐Relative/Friend House
☐Dr. Office ☐Walkway/Pathway_____☐Other____

What was the cause of your fall? ☐Tripped ☐Slipped ☐Dizziness ☐Seizure
☐Loss of Balance ☐Fainted/Blacked out ☐Other: _____

Were any of the following conditions present when you fell?

Ground conditions			**Behaviors** For each Yes*, answer additional *question* below		
Wet Ground.....	☐No ☐Yes	☐	Wearing shoes that did not fit properly.....	☐No ☐Yes*	☐
Icy/snowy Ground.....	☐No ☐Yes	☐	Wearing clothes that did not fit properly.....	☐No ☐Yes*	☐
Uneven Ground.....	☐No ☐Yes	☐	Not using necessary visual aid/glasses.....	☐No ☐Yes*	☐
Stepping up	☐No	☐	Not using necessary	☐No	☐

onto/down from a Curb.....Yes
Climbing up/going down stairs.....No Yes
Object in walkway/path.....No Yes
equipment.....Yes*
(cane, walker, shower seat, grab bars)

*Have you changed this behavior to prevent future falls? No Yes

N. Have you been anxious, worried or afraid you might fall? .....
No
Yes

O. Do you ever limit your activities, for example, what you do or where you go because you are afraid of falling?.....
No
Yes

If Yes, Explain:_____

P. Since we last talked, have you made any changes to your home or to your behavior to prevent future falls?.....
No
Yes

If Yes, which activities and why?_____

How often? All of the time Some of the time Rarely Doesn't know

Have you spent any of your own money to implement any of these changes?.....No___Yes

If Yes, how much?.....$_____

Were you reimbursed for any of these expenses?_No Yes

Q. Since we last talked, are you less fearful of falling?.....
No
Yes

If Yes, Explain why:_____

● Wrap up

Thank you again for participating in the Falls Preventions study. We will be calling you in another three months to see how you are doing.

R. Is there a best day of the week and/or time of day for us to call you so that the interview will be convenient for you?.....☐No ☐ Yes

If Yes, Day of week? ☐Sun ☐Mon ☐Tues ☐Wed ☐Thur ☐Fri ☐Sat

Time of day? ☐8am-12pm ☐12pm-4pm____☐4pm-8pm

☐Other:_____

☐Eastern ☐Central ☐Mountain ☐Pacific