NORC at the UNIVERSITY of CHICAGO

OMB No: xxxx-xxxx

EXIT

Form Approved
OMB No: xxxx-xxxx
Exp. Date: xx-xx-xxxx

Public Reporting burden of this collection of information is estimated at 15 minutes, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC/ATSDR Reports Clearance Officer, 1600 Clifton Road NW, MS D-74, Atlanta, GA 30333; Attn: PRA (xxxx-xxxx).

This survey is for Jane Doe. Please confirm that you are this person.

- ○ I am this person
- ○ I am NOT this person

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This survey can only be completed by Jane Doe. Thank you.

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Welcome to the Patient Falls Survey. We appreciate your continued help with this important study. Your participation is voluntary. You can refuse to answer a question or stop the interview at any time, and all information you provide is confidential, and will only be used for the purposes of this study.

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In general, would you say that your health is:

Excellent	Very Good	Good	Fair	Poor	Don't Know	Prefer not to Answer
○	○	○	○	○	○	○

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For purposes of this survey, you will be asked a series of questions about your health with a particular focus on falls. A fall is being defined as an event that resulted in a person unintentionally coming to rest on the ground, floor, or other lower level. Please keep this definition in mind as you complete the survey.

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If you have your falls tracking log available, please use it to help you answer the remaining questions.

Since the last time you took this survey, have you fallen?

Yes	No	Don't Know	Prefer not to Answer
○	○	○	○

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How many times did you fall since the last time you took this survey?

Number of falls

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Starting with the most recent fall, please answer the following items about up to three falls you had since you last took this survey.

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Thinking of the most recent fall:

Did the fall cause an injury? By injury, we mean the fall caused you to limit your regular activities for at least a day or go seek a health care professional.

Yes	No	Don't Know	Prefer Not to Answer
○	○	○	○

Did you get medical attention?

Yes	No	Don't Know	Prefer Not to Answer
◉	○	○	○

Was the medical attention you received provided by an Emory provider?

Yes	No	Don't Know	Prefer Not to Answer
○	○	○	○

What kind of medical attention did you receive? Please select all that apply.

- ☐ **Emergency Medical Services (EMT, Ambulance)**
- ☐ **Urgent Care Visit**
- ☐ **Admitted to Hospital**
- ☐ **Prefer not to Answer**
- ☐ **Emergency Room Visit**
- ☐ **Doctor's Office Visit**
- ☐ **Don't Know**

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Thinking of the second most recent fall:

Did the fall cause an injury? By injury, we mean the fall caused you to limit your regular activities for at least a day or go seek a health care professional.

Yes	No	Don't Know	Prefer Not to Answer
○	○	○	○

Did you get medical attention?

Yes	No	Don't Know	Prefer Not to Answer
◉	○	○	○

Was the medical attention you received provided by an Emory provider?

Yes	No	Don't Know	Prefer Not to Answer
○	○	○	○

What kind of medical attention did you receive? Please select all that apply.

- ☐ **Emergency Medical Services (EMT, Ambulance)**
- ☐ **Urgent Care Visit**
- ☐ **Admitted to Hospital**
- ☐ **Prefer not to Answer**
- ☐ **Emergency Room Visit**
- ☐ **Doctor's Office Visit**
- ☐ **Don't Know**

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Thinking of the third most recent fall:

Did the fall cause an injury? By injury, we mean the fall caused you to limit your regular activities for at least a day or go seek a health care professional.

Yes	No	Don't Know	Prefer Not to Answer
○	○	○	○

Did you get medical attention?

Yes	No	Don't Know	Prefer Not to Answer
◉	○	○	○

Was the medical attention you received provided by an Emory provider?

Yes	No	Don't Know	Prefer Not to Answer
○	○	○	○

What kind of medical attention did you receive? Please select all that apply.

- ☐ **Emergency Medical Services (EMT, Ambulance)**
- ☐ **Urgent Care Visit**
- ☐ **Admitted to Hospital**
- ☐ **Prefer not to Answer**
- ☐ **Emergency Room Visit**
- ☐ **Doctor's Office Visit**
- ☐ **Don't Know**

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Recently you visited your Emory provider and participated in a falls risk screening. Our records indicate that visit took place on 99/99/9999. Since that visit, has a health care professional done any of the following:

	Yes	No	Don't Know	Prefer not to Answer
Referred you to physical therapy?	○	○	○	○
Referred you to occupational therapy?	○	○	○	○
Referred you to an exercise program (such as Tai Chi or yoga)?	○	○	○	○
Referred you to an eye doctor?	○	○	○	○
Referred you to a foot doctor?	○	○	○	○
Recommended a change to one or more of your medications?	○	○	○	○
Recommended you use a cane or walker?	○	○	○	○

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Since the Emory visit, have you done any of the following:

	Yes	No	Don't Know	Prefer not to Answer
Gone to physical therapy?	○	○	○	○
Gone to occupational therapy?	○	○	○	○
Visited an eye doctor?	○	○	○	○
Visited a foot doctor?	○	○	○	○
Stopped, switched, or reduced one or more of your medications?	○	○	○	○
Used a cane or walker?	○	○	○	○
Reviewed brochures or other materials on how to prevent falls?	○	○	○	○

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Since the Emory visit, have you participated in any of the following exercise programs: Tai Chi, Matter of Balance, or some other exercise?

Tai Chi	Matter of Balance	Other Exercise	Don't Know	Prefer not to Answer
○	○	○	○	○

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Since the Emory visit, have <u>you</u> made any of the following changes to your home to prevent falls:

	Yes	No	Don't Know	Prefer not to Answer
Installed handrails	○	○	○	○
Replaced stairs with ramps	○	○	○	○
Removed clutter	○	○	○	○
Removed mats/rugs	○	○	○	○
Removed loose cords	○	○	○	○
Improved lighting	○	○	○	○
Repaired unsafe/unsteady furniture	○	○	○	○
Moved furniture	○	○	○	○
Moved to a safer home	○	○	○	○

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Do you take:

	Yes	No	Don't Know	Prefer not to Answer
Medicine prescribed for you to help you sleep such as zolpidem (Ambien), zaleplon (Sonata), or eszopiclone (Lunesta)?	○	○	○	○
Over-the-counter medicine to help you sleep such as diphenhydramine (Benedryl, ZZZQuil, Tylenol PM) or doxylamine (Unisom)?	○	○	○	○
Opioid medicine prescribed for you to help with pain? These might include tramadol (Ultram), oxycodone (Roxicodone, Percocet, Oxycontin), hydrocodone (Lortab, Vicodin), morphine (MsContin), hydromorphone (Dilaudid), or fentanyl (Duragesic).	○	○	○	○
Non-opioid medicine prescribed for you to help with pain, such as ibuprofen (Motrin), naproxen (Naprosyn), or diclofenac (Voltaren)?	○	○	○	○
Over the counter medicine to help with pain such as ibuprofen (Motrin, Advil), acetaminophen (Tylenol) or naproxen (Aleve)?	○	○	○	○
Medicine prescribed for you to help your mood or for sadness, such as sertraline (Zoloft), citalopram (Celexa), or duloxetine (Cymbalta)?	○	○	○	○
Medicine prescribed for you to help with anxiety or nervousness, such as alprazolam (Xanax), lorazepam (Ativan), or diazepam (Valium)?	○	○	○	○
Medicine prescribed for you to help with mood stability, such as risperidone (Risperdal), aripiprazole (Abilify), or quetiapine (Seroquel)?	○	○	○	○
Vitamin D or a multivitamin?	○	○	○	○

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How many prescription medications do you take regularly?

[ ] number of medications

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In the **last three months**, on average, how many days per week did you have any alcohol to drink?

0 Zero or Less than One Day per Week	1 Day per Week	2 Days per Week	3 or More Days per Week	Don't know	Prefer not to Answer
○	○	○	○	○	○

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Did you use marijuana in the **last 30 days**?

Yes	No	Don't know	Prefer not to Answer
○	○	○	○

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Those are all the questions. Thank you for taking the time to participate today.

You will be contacted again in approximately three months to answer follow-up questions about your experience with falls. Please remember to track your survey participation and falls in your falls tracking log, which was provided to you by your medical provider. If you don't have the falls tracking log, you can use any calendar. Tracking this information will make it easier to answer the questions in the follow-up survey.

As a token of our appreciation, we will send you postage stamps valued at $3. Please confirm that your mailing address is:

Jane Doe
1234 N Road
Chicago, ILLINOIS 60603

- ○ **My address is correct.**
- ○ **My address is NOT correct.**
- ○ **Please do NOT send stamps.**

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Please enter your mailing address

FIRST AND LAST NAME:

STREET ADDRESS

STREET ADDRESS (Optional)

CITY

STATE

Select an answer...

ZIP CODE

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Thank you for participating! If you have any questions, you can contact the study team at xxxx@norc.org

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Thank you for your participation.