

EXIT

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

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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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If you experience technical issues, please call xxxxxxxxxx or email xxxxxxxxxx for assistance.

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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
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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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
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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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
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Did you get medical attention?

Yes	No	Don't Know	Prefer Not to Answer
<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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

Yes	No	Don't Know	Prefer Not to Answer
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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

- | | |
|--|--|
| <input type="checkbox"/> Emergency Medical Services (EMT, Ambulance) | <input type="checkbox"/> Emergency Room Visit |
| <input type="checkbox"/> Urgent Care Visit | <input type="checkbox"/> Doctor's Office Visit |
| <input type="checkbox"/> Admitted to Hospital | <input type="checkbox"/> Don't Know |
| <input type="checkbox"/> Prefer not to Answer | |

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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
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Did you get medical attention?

Yes	No	Don't Know	Prefer Not to Answer
<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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

Yes	No	Don't Know	Prefer Not to Answer
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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

- | | |
|--|--|
| <input type="checkbox"/> Emergency Medical Services (EMT, Ambulance) | <input type="checkbox"/> Emergency Room Visit |
| <input type="checkbox"/> Urgent Care Visit | <input type="checkbox"/> Doctor's Office Visit |
| <input type="checkbox"/> Admitted to Hospital | <input type="checkbox"/> Don't Know |
| <input type="checkbox"/> Prefer not to Answer | |

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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
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Did you get medical attention?

Yes	No	Don't Know	Prefer Not to Answer
<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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

Yes	No	Don't Know	Prefer Not to Answer
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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

- | | |
|--|--|
| <input type="checkbox"/> Emergency Medical Services (EMT, Ambulance) | <input type="checkbox"/> Emergency Room Visit |
| <input type="checkbox"/> Urgent Care Visit | <input type="checkbox"/> Doctor's Office Visit |
| <input type="checkbox"/> Admitted to Hospital | <input type="checkbox"/> Don't Know |
| <input type="checkbox"/> Prefer not to Answer | |

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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?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Referred you to occupational therapy?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Referred you to an exercise program (such as Tai Chi or yoga)?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Referred you to an eye doctor?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Referred you to a foot doctor?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Recommended a change to one or more of your medications?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Recommended you use a cane or walker?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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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?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Gone to occupational therapy?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Visited an eye doctor?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Visited a foot doctor?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Stopped, switched, or reduced one or more of your medications?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Used a cane or walker?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Reviewed brochures or other materials on how to prevent falls?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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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
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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

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

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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)?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Over-the-counter medicine to help you sleep such as diphenhydramine (Benedryl, ZZZQuil, Tylenol PM) or doxylamine (Unisom)?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
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).	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Non-opioid medicine prescribed for you to help with pain, such as ibuprofen (Motrin), naproxen (Naprosyn), or diclofenac (Voltaren)?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Over the counter medicine to help with pain such as ibuprofen (Motrin, Advil), acetaminophen (Tylenol) or naproxen (Aleve)?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Medicine prescribed for you to help your mood or for sadness, such as sertraline (Zoloft), citalopram (Celexa), or duloxetine (Cymbalta)?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Medicine prescribed for you to help with anxiety or nervousness, such as alprazolam (Xanax), lorazepam (Ativan), or diazepam (Valium)?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Medicine prescribed for you to help with mood stability, such as risperidone (Risperdal), aripiprazole (Abilify), or quetiapine (Seroquel)?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Vitamin D or a multivitamin?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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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
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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

Yes	No	Don't know	Prefer not to Answer
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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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

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.