**EQUIPMENT FORM**

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| Participant Number:  |  | Participant Initials:  | If no equipment please tick the box below | RA’s Initials |
|  | **Date of Baseline data collection** |  |  |  |
|  | **Date of 3 month data collection** |  |  |  |
|  | **Date of 6 month data collection** |  |  |  |
|  | **Date of 9 month data collection** |  |  |  |
|  | **Date of 12 month data collection** |  |  |  |

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| **Instructions**The following form should be used to record if the resident has bought or been given any equipment to help them cope with a health problem (e.g. frame, hoist, bath aids etc). At baseline (date of consent) we need to know what equipment the patient is using, irrespective of how long they have had it for. At 3, 6, 9 and 12 months, we need to know about any additional equipment purchased since the previous visit. Please record what equipment the resident has at the date of consent and during the trial. In the event that the resident does not have equipment aids at baseline, or where no equipment has been purchased since the last time point please tick the box above indicating no equipment purchased. Each resident should have their own Equipment Form, which must be updated throughout the trial.  |

**If yes, please specify the equipment in the table below and record whether the resident has purchased or been given it. If they bought it please also specify how much it cost: (Additional items can be included at the end of the list)**

**To identify who purchased the item of equipment please choose the appropriate abbreviation from the following:**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 1 | Patient | 2 | Social Service | 3 | Health Budget | 4 | Care Home | 5 | Unknown |

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| **Item** | **Purchased by** (insert number as appropriate) | **Date received** | **Details** | **Cost to patient (if known)** |
|  |  |  |  | £ |
|  |  |  |  | £ |
|  |  |  |  | £ |
|  |  |  |  | £ |
|  |  |  |  | £ |
|  |  |  |  | £ |
|  |  |  |  | £ |
|  |  |  |  | £ |
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|  |  |  |  | £ |

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**Falls in Care Homes Study**

**FinCH**

**Primary Care or Community Services log**

This Primary Care or Community Services continuation is for use with the Baseline CRF, 3, 6, 9 and 12 months follow-up.

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| --- | --- | --- |
| Participant Number:  | Participant Initials:  | Today’s Date: |
| Please indicate at which time point this continuation takes effect from**:**  | 3 months | 6 months | 9 months | 12 months |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Date** | **GP** | **Practice Nurse** | **District Nurse** | **Physio** | **OT** | **Podiatrist** | **Social Worker** | **Other** | **Additional information** | **Privately funded**  |
| **(in****hours)** | **(Out of hours)** | **Yes** | **No** |
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**Falls in Care Homes Study (FinCH)**

**MEDICATIONS FORM**

**Reminder** - please record continence products on medication sheet. Please note these may not be on the MAR’s sheets and may be in the care home notes.

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| --- | --- | --- | --- | --- |
| Participant Number:  |  | Participant Initials:  | If no meds or no change please tick the box below | RA’s Initials |
|  | **Date of Baseline data collection** |  |  |  |
|  | **Date of 3 month data collection** |  |  |  |
|  | **Date of 6 month data collection** |  |  |  |
|  | **Date of 9 month data collection** |  |  |  |
|  | **Date of 12 month data collection** |  |  |  |

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| **Instructions**The following table should be used to record any medications taken by a resident from three months prior to the date of consent and during the trial. Each resident should have their own Medication Form, which must be updated throughout the trial and record if any medications are stopped or new ones started. If medication was started pre-trial and start date unknown state, ‘pre-trial’ as start date. At each data collection time point please start collecting data from the date of the last entry. \*End date – to be updated when end date is known. If the resident is still taking the medicine (with no changes) at the end of the study please report ‘ongoing’.For units/frequency and route please choose the appropriate abbreviation from the following: |
| **Dose units:** |  **Frequency:**  | **Route:**  |
| mg | h | every hour | IV | intravenously | R | Rectal |
| µg | od | once daily | Inh | Inhalation | SC | subcutaneously |
| g | qod | every other day | IM | intramuscularly | A | Aural (ear) |
| ml | bd | twice a day | Top | topical | Trans | Transdermal |
| mg / ml | tid | three times a day | O | Ophthalmic (eye)  |  |  |
| g / ml | qid | four times a day | N | Nasal |  |  |
| other (specify) | ow | once weekly | Po | by mouth  |  |  |
|  | Prn  | as required |  |  |  |  |

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| --- | --- | --- | --- | --- | --- |
| **Name of Drug** | **Start Date**(dd/mm/yy)if known | **Dose** | **Frequency** | **Route** | **End Date**(dd/mm/yy)or ongoing \* |
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