REFORM

# REFORM: FALLS TELEPHONE DATA COLLECTION SHEET

Thank you for ringing us to let us know you have had a fall. I would like to ask you some questions to find out more about your fall please.

Centre number: ☐☐

Participant's trial ID number: ☐☐☐☐☐

Participant's name: _____

Participant's telephone number: _____

1. Date of phone call ☐☐ / ☐☐ / 2 0 ☐☐
   *Day* *Month* *Year*

2. Date of fall ☐☐ / ☐☐ / 2 0 ☐☐
   *Day* *Month* *Year*

3. What was the cause/reason for your fall?

| Trip | Slip | Turning | Legs gave way | Dizzy |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ |

Other _____

4a. Where did you fall?

- Inside your own home? ☐
- Inside, but not in your own home? ☐
- Outside? ☐

4b. If you fell inside was it:

- On the one level ☐
- Accessing the shower/bath ☐
- Getting out of bed ☐
- Getting out of a chair ☐
- Walking up or down stairs ☐
- Accessing the toilet ☐
- Other* ☐

*Please specify if 'Other' _____

4c. If you fell outside was it:

| | | | |
|---|---|---|---|
| Car park/driveway | ☐ | Crossing a street | ☐ |
| Garden park/grassed area | ☐ | Getting into or out of a vehicle | ☐ |
| On a bus or train | ☐ | On a footpath | ☐ |
| On a kerb | ☐ | On a step/escalator | ☐ |
| On the one level | ☐ | Other* | ☐ |

*Please specify if 'Other' _____

5. What footwear were you wearing when you fell?

| Barefoot | Slipper | Shoe | Can't remember | Other* |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ |

*Please specify if 'Other' _____

6. Were you using a walking aid when you fell? Yes ☐ No ☐

7. Were you wearing an insole/orthotic in your shoe when you fell? Yes ☐ No ☐

8. Did you suffer any injuries as a result of the fall?

| | |
|---|---|
| No injury | ☐ |
| Had some superficial wounds eg bruising, sprain, cut, abrasion | ☐ |
| Broken bones* | ☐ |

*Please specify type of broken bone _____

9. Did you have to stay in hospital overnight because of this fall? Yes ☐ No ☐

9a. If 'Yes', how many nights did you stay in hospital? ☐☐☐