CONFIDENTIAL

OTIS Study

Occupational Therapist Intervention Study

Participant 12 Month Questionnaire

For office use only

Centre number: | | |

Participant's trial ID number: | | | | | |

Date questionnaire sent: | | | / | | | / | 2 | 0 | | |

Day *Month* *Year*

Funded by:

NIHR Health Technology Assessment programme funded project

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THE UNIVERSITY of York

PLEASE READ ALL THE INSTRUCTIONS BEFORE COMPLETING THE QUESTIONNAIRE

Thank you for agreeing to take part in this study. The responses you give in this questionnaire will help us find out the best way to help reduce falls in people who are over 65 years old.

Please answer ALL the questions. Although some of the questions may not seem relevant to yourself or may appear similar, they do give us valuable information.

If you find it difficult to answer the question, please give the best answer you can.

Please follow the instructions for each section carefully.

For each section, if you are asked to put a cross in the box, please use a cross rather than a tick, as if you were filling out a ballot paper.

For example in the following question, if your answer to the question is 'yes', you should place a cross firmly in the box next to yes.

Do you drive a car? Yes ☒

No ☐

If you are asked to write your answer, please do so by entering your answer in the box provided, for example:

How old are you? | 7 | 5 | years

Please use a black or blue pen for all the questions.

Please do not use a pencil or any other coloured pen.

If you have any queries or problems completing this questionnaire please phone [insert contact number] to speak to one of the OTIS Trial Support Officers, [insert contact names], or email [insert email addresses].

SECTION 1

This section asks about any falls you have had and some general information about you.

Please enter the date you are completing this questionnaire: ☐☐ / ☐☐ / 2 0 ☐☐

Day *Month* *Year*

1. Have you fallen in the **past 4 months**?
(Please cross one box only)

☐ Yes ☐ No ☐ Don't know

1a. If 'Yes', how many falls did you have in the **past 4 months**? ☐☐

2. During the **past 4 weeks** how often have you worried about having a fall?
(Please cross one box only)

All of the time	Most of the time	A good bit of the time	Some of the time	A little of the time	None of the time
☐	☐	☐	☐	☐	☐

SECTION 2: This section asks about your health in general

Under each heading, please tick the ONE box that best describes your health **TODAY**.

MOBILITY

I have no problems in walking about ☐

I have slight problems in walking about ☐

I have moderate problems in walking about ☐

I have severe problems in walking about ☐

I am unable to walk about ☐

SELF-CARE

I have no problems washing or dressing myself ☐

I have slight problems washing or dressing myself ☐

I have moderate problems washing or dressing myself ☐

I have severe problems washing or dressing myself ☐

I am unable to wash or dress myself ☐

USUAL ACTIVITIES *(e.g. work, study, housework, family or leisure activities)*

I have no problems doing my usual activities ☐

I have slight problems doing my usual activities ☐

I have moderate problems doing my usual activities ☐

I have severe problems doing my usual activities ☐

I am unable to do my usual activities ☐

PAIN/DISCOMFORT

I have no pain or discomfort ☐

I have slight pain or discomfort ☐

I have moderate pain or discomfort ☐

I have severe pain or discomfort ☐

I have extreme pain or discomfort ☐

ANXIETY/DEPRESSION

I am not anxious or depressed ☐

I am slightly anxious or depressed ☐

I am moderately anxious or depressed ☐

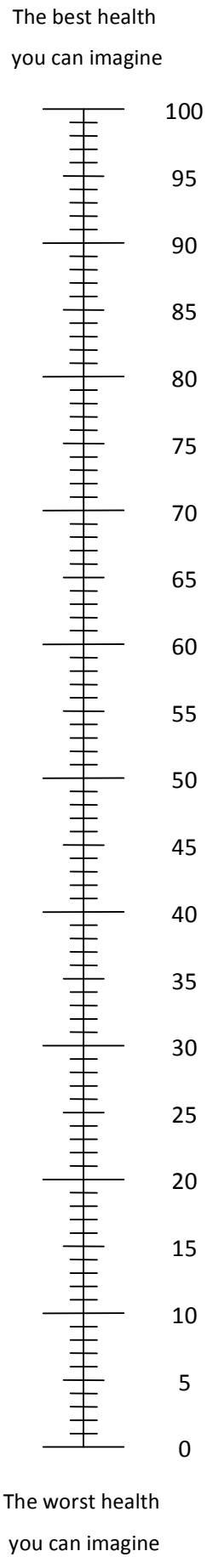
I am severely anxious or depressed ☐

I am extremely anxious or depressed ☐

- We would like to know how good or bad your health is TODAY.
- The scale is numbered from 0 to 100.
- 100 means the <u>best</u> health you can imagine.

  0 means the <u>worst</u> health you can imagine.
- Mark an X on the scale to indicate how your health is TODAY.
- Now, please write the number you marked on the scale in the box below.

YOUR HEALTH TODAY = | | | |



SECTION 3

This section asks about the health care you have received over the past four months

If the health care you received was related to a fall, record this in the "**About a fall**" column.
If the health care was for any other reason, record this in the "**Other reason**" column.

Please fill in all of the boxes, even if the answer is "0"

FOR EXAMPLE:

Over **the past four months**, how many times have you:	**About a fall**	**Other reason**
Seen your **GP** at your GP practice or at home?	1 0	0 0

This example would indicate that you have:
- seen your '**GP at your GP practice**' ten times in the **past 4 months** related to a fall and
- not seen your '**GP at your GP practice**' in the **past 4 months** for any other reason.

1. Care from the NHS NOT IN the hospital:

Over **the past four months**, how many times have you:

		About a fall	Other reason
a.	Seen your **GP** at your GP practice or at home?	*If none enter '0'*	*If none enter '0'*
b.	Seen a **nurse** at your GP practice or at home?	*If none enter '0'*	*If none enter '0'*
c.	Seen an **occupational therapist**?	*If none enter '0'*	*If none enter '0'*
d.	Seen a **physiotherapist**?	*If none enter '0'*	*If none enter '0'*

2. Care from the NHS IN the hospital:

Over **the past four months**, how many times have you:

		About a fall	Other reason
a.	Attended a **hospital clinic** as an outpatient? *(please record the number of times in the boxes)*	*If none enter '0'*	*If none enter '0'*
b.	Visited **Accident and Emergency**? *(please record the number of times in the boxes)*	*If none enter '0'*	*If none enter '0'*

c. Visited hospital as a **day case**?
(admitted and discharged in the same day)
e.g. admitted at 2am and discharged at 10am
OR admitted at 8am and discharged at 10pm

☐☐ *If none enter '0'* ☐☐ *If none enter '0'*

d. How many nights have you stayed in hospital as an **in-patient**?
(admitted and discharged on a different day)

☐☐ *If none enter '0'* ☐☐ *If none enter '0'*

3a. Does a paid care worker visit you at home (e.g. to help with your personal care, eating and drinking, taking medicines, household domestic duties)?
(Please cross one box only)

☐ Yes ☐ No

3b. If 'YES', thinking about **the last 4 months**, typically how many days a week did a care worker visit? ☐☐☐

SECTION 4

This section asks about any extra costs you have had in the **past four months**.

1a. In **the last 4 months**, have <u>you</u> had to buy any equipment (e.g. a bed), or paid to have any changes made to your house (e.g. installed a stair lift) due to ill health?
(Please cross one box only)

☐ Yes ☐ No (go to question 2)

1b. If 'YES' please tell us the item and how much it cost.
(Please enter the cost to the nearest pound)

Item bought	Cost
	£ ☐☐☐☐
	£ ☐☐☐☐
	£ ☐☐☐☐

2. How much have you had to pay for travel costs (e.g. bus fare, parking fees) to attend any appointments (e.g. hospital, GP) during the **last 4 months**?

£ ☐☐☐.☐☐

SECTION 5

This section asks about falls services that you have received in the last 12 months and whether you have any equipment in your home for another person.

1. Not including any services you have received for the OTIS trial, have you been to a falls clinic/ falls service in **the last 12 months**? (This may include attending a group session where home modifications and exercises to help prevent falls were discussed.)
(Please cross one box only)

☐ Yes ☐ No

2a. Not including any visits you have received for the OTIS trial, has a health or social care worker assessed your home and provided advice about preventing falls in **the last 12 months** (e.g. checked your falls safety at home and/or provided equipment in your home to prevent falls)?
(Please cross one box only)

☐ Yes ☐ No

2b. If 'YES', who assessed your home?
(Please cross one box only)

☐ Occupational therapist ☐ Home carer or helper

☐ District nurse ☐ Social worker

☐ Physiotherapist ☐ Other *(please specify):* _____

3a. Do you have any equipment in your home (such as grab rails or toileting equipment) that has been provided **for another person that you live with** that you use?
(Please cross one box only)

☐ Yes ☐ No

3b. If 'YES', what equipment do you have at home?

4. Do you want to receive results from the study?
(Please cross one box only)

☐ Yes ☐ No

Thank you for taking the time to complete this questionnaire. Please return it to the York Trials Unit at the University of York in the pre-paid envelope provided.