Admin code: ☐☐☐

THE UNIVERSITY of York

OTIS

Centre number: ☐☐

Trial ID number: ☐☐☐☐☐

SCREENING FORM

Please answer the following questions:

1. What is your date of birth? ☐☐ / ☐☐ / 1 9 ☐☐
   Day / *Month* / *Year*

2. Are you? Male ☐ Female ☐

3a. In the last 12 months, have you had any fall including a slip or a trip following which you have come to rest on the ground, floor, or lower level? *(Please cross one box only)* Yes ☐ No ☐

3b. If 'YES', how many times have you fallen? ☐☐☐

3c. Did you attend hospital for any of the falls? *(Please cross one box only)* Yes ☐ No ☐

4. 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
☐	☐	☐	☐	☐	☐

5. Are you able to walk 10 feet today, with the use of a walking aid if needed? *(Please cross one box only)* Yes ☐ No ☐

6. Are you on a waiting list for occupational therapy? *(Please cross one box only)* Yes ☐ No ☐

7. Have you had your home environment assessed for falls hazards or equipment to prevent falls in the past 12 months? *(Please cross one box only)* Yes ☐ No ☐

8. Do you suffer from either dementia or Alzheimer's disease? *(Please cross one box only)* Yes ☐ No ☐

Please enter the date you are completing this form: ☐☐ / ☐☐ / 2 0 ☐☐
Day / *Month* / *Year*

CONTACT SHEET

If you would like to take part in the OTIS trial please can you tell us your:

Title:

Forename:

Surname:

Address:

Post code:

Telephone number:

Your mobile number:

Your email address:

GP name:

GP Address:

Thank you for taking the time to complete these questions.
Please return these forms in the pre-paid envelope provided to the York Trials Unit.