Appendix B

Falls Prevention Mobile Clinic Assessment Measures

1 – Nurse Assessment

2 – Vision Screening

3 – Pharmacist Assessment

4 – Physiotherapy Station

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Nurse Assessment

I. Pain Assessment

1. How much pain/ache/soreness/discomfort have you had during the <u>past week</u>?

0	**1**	**2**	**3**	**4**	**5**
No Pain	Slight	Mild	Moderate	Severe	Extreme

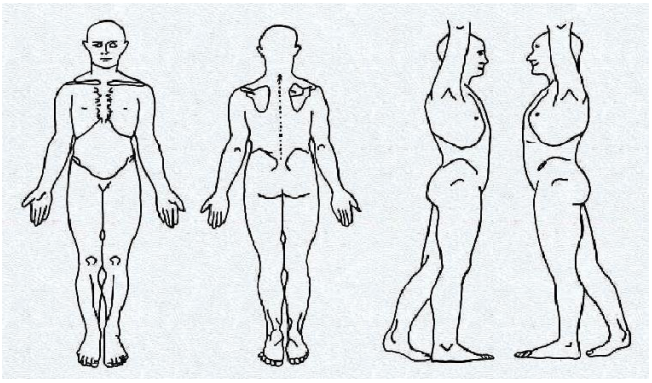
2. During the past week, how much did pain interfere with your normal activities?
(Including both outside the home and housework)

0	**1**	**2**	**3**	**4**	**5**
None	Slightly	Mildly	Moderately	Severely	Extremely

3. If you do, **<u>WHEN</u>** do you feel it?

☐ All the time ☐ Early morning ☐ Only when I move ☐ Others _____

4. If you do, **<u>WHERE</u>** is your pain located? *(mark all the areas on the chart below)*



FRONT BACK RIGHT SIDE LEFT SIDE

5. Are you taking any medications for pain? ☐ Yes ☐ No

6. What are you doing to cope with pain?

_____

7. Have you talked to your doctor regarding pain? ☐ Yes ☐ No
If Yes, please explain: _____

Nurse Recommendations for Pain:
*Note to Nurse: If the client is on a scale of **3 or higher** for questions 1 or 2, provide recommendation to consult with physician*

☐ No recommendation
☐ Consult with your physician regarding initiating or reviewing pain management

II. Bone Health Assessment

Height: ☐☐ feet ☐☐ inches Weight: ☐☐☐ pounds

Do you think your height has changed? ☐ Yes ☐ No

Kyphosis: ☐ Yes ☐ No

1. Family history of osteoporosis? ☐ Yes ☐ No

2. Have you ever had a fracture from a fall after the age of 40?
   ☐ Yes ☐ No ☐ Not Known

   If yes, which body part? _____

3. Are you taking any medications for osteoporosis? ☐ Yes ☐ No

4. Do you currently smoke?: ☐ Yes ☐ No

   If yes, If yes, how many cigarettes per day?
   ☐ Less than 5 ☐ More than 5

5. Are you a past smoker? ☐ Yes ☐ No
   If yes, when did you quit? _____ Years ago

   If yes, how many cigarettes per day?
   ☐ Less than 5 ☐ More than 5

6. How much alcohol do you drink per week? (12 oz beer, 4 oz wine, 1.5 oz spirits)
   ☐ None ☐ > 1 ☐ 1-3 ☐ < 3

7. How many caffeine drinks do you consume per day? (Coke, coffee, tea)?
   ☐ None ☐ > 1 ☐ 1-3 ☐ < 3

Nurse Recommendations for bone health:

☐ Consult with your physician regarding bone health to decide if you need any further investigations or treatment to keep your bones strong.

III. Sleeping Pattern Assessment

8. Do you have difficulty sleeping? ☐ Yes ☐ No

9. Do you take a sleep medication? ☐ Yes ☐ No

10. Do you get up at night to use the bathroom? ☐ Yes ☐ No

    If yes, on average how many times per night? _____

III. Blood Pressure Monitoring

1. Do you get dizzy or lightheaded when you stand from sitting position or lie down from standing position? ☐ Yes ☐ No

After seated for 5 min: Systolic / Diastolic = _____

Immediately after standing: Systolic / Diastolic = _____

Nurse Recommendations for Blood Pressure:

- ☐ Your postural blood pressure is within **normal** range. However, you should continue to monitor your blood pressure for further changes.
- ☐ Your change in blood pressure indicates you may have **postural hypotension**. You should follow-up with your physician. *Please refer to the handout for further information on postural hypotension.*
- ☐ Your blood pressure is **greater than** 140 systolic and/or greater than 90 diastolic and you should follow-up with your physician regarding ways to lower your blood pressure.
- ☐ Your blood pressure is **less than** 110 systolic and you should follow-up with your physician regarding this.

Note for nurse:
Normal: Less than or equal to 140/90
High: Greater than 140 systolic and/or greater than 90 diastolic
Low: Less than 110 systolic

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Vision Screening

Name: _____

I. Distance Vision Testing

☐ Unable to test

☐ Tested with:
- ☐ No glasses
- ☐ Distance vision glasses
- ☐ Near vision glasses
- ☐ Bifocals
- ☐ Progressive

Results:

- ☐ 20/40 Normal
- ☐ 20/60 Moderate
- ☐ 20/200 Moderate to severe
- ☐ 20/400 Severe
- ☐ <20/400 Profound

Conduct pinhole test if vision was NOT 20/40

Pinhole test:
- ☐ Unable to test with pinhole
- Improved vision *if vision < 20/40* ☐ Yes ☐ No

Recommendations for vision screening:

☐ No recommendation made
☐ Your vision is within the normal range (20/40), however, IF you have not had your vision tested in the last 2 years, consult an Optometrist.
☐ Your vision did not screen in the normal range; however, it improved with the pinhole mask. Consult an Optometrist for further testing.
☐ Your vision did not screen in the normal range and it did NOT improve with the pinhole mask. Consult your family physician and/or an Ophthalmologist for further testing.

If the client wears bifocals, provide the following recommendation:

☐ You should be advised that these glasses can contribute to falls by blurring obstacles at ground level. It is recommended that you wear a pair of single-lens distance glasses when walking outside your home. This is particularly important when walking in the street, on stairs and in unfamiliar surroundings.

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Pharmacist Assessment

I. Medication History

1. Who helps you with your medication? _____
2. Allergies/Type of reaction:_____
3. Taking medications for osteoporosis: ☐ Yes ☐ No
4. Patient taking drugs that are high risk for osteoporosis:
   - ☐ Long term steroids
   - ☐ Other drugs _____
   - ☐ Anti-androgens for prostate cancer
   - ☐ None

Pharmacist recommendations for current medications:

☐ None

☐ Some of your current medications need review. Recommend consulting with your family physician for review of these medications. *Please complete the table below.*

Medications that Need a Review	Rationale for Reviewing

Pharmacist recommendations for pain & sleep management medications:

Pain Management Medication	Sleep Medication
☐ No new recommendation required	☐ No new recommendation required
☐ Current medications need a review Specify:	☐ Current medications need a review Specify:
☐ Additional medications are recommended Specify:	☐ Additional medications are recommended Specify:
Rationale for review/addition	Rationale for review/addition

II. Calcium Intake

The recommended calcium intake for seniors is 1500 mg/day from diet and/or supplements.

1. Do you take calcium supplements? ☐ Yes ☐ No
   If no, reason: _____
   If yes how much? ☐☐☐☐ mg
   If yes, what type? _____

2. Calcium intake from dairy products or calcium fortified beverages ☐☐☐☐ mg

Total calcium intake = ☐☐☐☐ mg

Pharmacist Recommendations for Calcium Intake:

☐ No change required

☐ Increase calcium from **diet**:
- ☐ Milk (1 cup = 300 mg)
- ☐ Calcium fortified orange juice, soy, rice (1 cup = 300 mg)
- ☐ Yogurt (175ml = 200 mg)
- ☐ Cheese (2 slices processed cheese or 25g firm = 200 mg)
- ☐ Other _____

☐ Supplement with _____mg **calcium** citrate daily *(bowel disease, absorption disorders, taking antacids, H2 blockers, or if calcium will be taken without food, or if carbonate not tolerated)*

☐ Supplement with _____mg **calcium** carbonate or citrate daily – either type is appropriate if none of the above apply

☐ Needs to decrease, *by how much*: _____

Note to Pharmacist: Please review the types of products (types, forms) available.

III. Vitamin D Intake

The recommended vitamin D intake for seniors is between 800 to 2000 IU/day from diet and/or supplements.

1. Do you take a vitamin D supplement? ☐Yes ☐No
   If yes how much? ☐☐☐☐ IU

Pharmacist Recommendations for Vitamin D Intake:

☐ No change required
☐ Supplement with _____IU **Vitamin D daily**
- ☐ Multi-vitamin Supplement (check amount of Vit D per dose)
- ☐ Calcium supplement with Vit D (check amount of Vit D per dose)

☐ Needs to decrease

Comments: _____

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Physiotherapist Station

Client Name: _____

Falls Risk:

☐ Very low
☐ Mild
☐ Marked
☐ Low
☐ Moderate
☐ Very Marked

I. Physical Activity

1. What types of physical activities are you currently involved in for the last 7 days?

Activity	How often per week	Duration
☐ None		
☐ Walking		
☐ Swimming		
☐ Osteofit		
☐ Tai Chi		

II. Mobility Aide

Current mobility aide used:

1. Is the current mobility aide(s) correctly used ☐ Yes ☐ No ☐ Not applicable
2. Does the current mobility aide(s) need adjustment or repair ☐ Yes ☐ No ☐ Not applicable
   If yes, what type? _____

Physiotherapist recommendations for mobility aide:

Does the current mobility aide(s) needs to be changed?

☐ No: No new recommendation
☐ Yes: (if currently **NOT** using a mobility aide) Acquire a new mobility aide:
☐ Cane ☐ Walker ☐ Wheelchair ☐ Other_____
☐ Yes: Change current mobility aide to:
☐ Cane ☐ Walker ☐ Wheelchair ☐ Other_____

III. Hip Protectors

1. Have you heard of hip protectors ☐ Yes ☐ No
2. Do you wear hip protectors? ☐ Yes ☐ No
   If no, are you willing to wear a hip protector? ☐ Yes ☐ No
   Why not? _____
3. Do you have Extended Medical/DVA? ☐ Yes ☐ No

Physiotherapist Recommendations for Hip Protectors:

☐ Discussed by giving brochure
☐ Given information on where to get them
☐ Recommended client to get hip protectors
☐ Measured the client and gave them their measurements

Type: _____
Model: _____
Hip size: _____ Waist size: _____ Hip Protector Size: _____

IV. Personal Alarm System

(Note to Physiotherapist: See Health Profile Form to determine if they live alone, have a personal alarm system) Doe the participant currently have personal alarm? – Yes or No

Physiotherapist Recommendations:

☐ Discussed by giving brochure
☐ Recommended client to get Lifeline

Comments: _____
_____

Physiotherapist Recommendations for at home Exercises:

For Strength	With Thera-bands	Reps	Times in a day	Using Hands	No Hands
❑ Walking from Room to Room					
❑ Front Knee Strength					
❑ Rising Up on Toes					
❑ Back Knee Strength					
❑ Side Hip Strength					
❑ Toe Raises					
❑ Wall Push Ups					

For Balance	Reps	Times in a day	Using Hands	No Hands
❑ Knee Bends				
❑ Walking Backwards				
❑ Sideways walking				
❑ Heel toe standing				
❑ Heel toe walking				
❑ One leg stand – holding for _____ secs				
❑ Sit to Stand				
❑ Reaching				

Are you willing to participate in group classes: ☐ Yes ☐ No

Physiotherapist Recommendations for Community/Group Activity Classes:

Activity	Where	When	How often
❑ Osteofit			
❑ Tai Chi			
❑ Yoga			
❑ Aquafit			