

OPACH Telephone Follow-up Survey of Falls Reported on Falls Calendar

Participant Name: Last _____ First _____ MI _____
Participant ID: _____
Staff ID: _____
Date of interview (mm-dd-yy): _____
Completed by: ☐₁ Participant ☐₂ Proxy

Prior to call, record from calendar:

i. Calendar month and year: _____

ii. # of falls reported: _____

iii. Dates of falls: _____

This information is collected from OPACH participants who have reported at least one fall on their calendar page. If, during the attempts to reach the participant, you learn that she will be unable to complete the interview (e.g., due to a prolonged hospital or nursing home stay, a head injury, or other reason that will make it impossible to reach her), collect Sections A and B (to the best of their ability) from a willing proxy who is knowledgeable about the circumstances surrounding her recent fall(s).

Hello. This is: _____ calling from the WHI Physical Activity Study.

We received your recent Falls Calendar page. Thank you for sending the page back to us.

We'd like to ask you some questions about your recent fall(s). Is now a good time to talk?

If NO: When may I call you back? **END CALL**

If YES: **CONTINUE**

P.1. Looking at your calendar, I see you reported a fall [xx falls]. Were you injured because of the fall [any of the falls] you reported on the calendar?

☐₀ No → Go to Section B

☐₁ Yes → Go to Section A

Section A. Injury Falls

I'd like to ask you about the fall [all of the falls] you reported on your calendar that caused an injury.

A.1. You reported a fall [falls] on [x] days [insert number of days with falls from calendar] on your calendar. Did this fall cause [How many of these falls caused] an injury?

☐ If "0", skip to Section B.

- A.2. You reported falling on mm-dd, mm-dd, and mm-dd (list all dates on which falls are reported). Considering that date [those dates], and remembering the best that you can, was this the date of the fall that caused the injury? [on which of these dates did you have the first fall that caused injury]?

If woman is unsure of exact date of injury fall(s), write DK.

Injury Fall #1:	___	___	/	___	___	/	___	___
	month			day			year	

The next set of questions applies specifically to the fall on that date. [If at any point during the questions the respondent tries to answer for more than one fall, or combine falls in any way, remind them that they should be specifically answering about the fall that caused an injury on that specific date, xx/xx/xx.]

- A.3. Were you at home or away from home at the time of the [first, second, third] fall that caused an injury?

- ☐₁ At home
☐₂ Away from home

- A.4. Were you inside or outside your home or apartment at the time of the fall?

- ☐₁ Inside
☐₂ Outside

- A.5. Were you walking at the time of the fall?

- ☐₀ No → Go to A8
☐₁ Yes → Continue

- A.6. Were you walking for exercise at the time of the fall?

- ☐₀ No → Go to A8
☐₁ Yes → Continue

- A.7. During the walk when you fell, how many minutes were you planning to walk, that is, if you had not fallen?

 Minutes → Go to A11

- A.8. Were you exercising, other than walking for exercise, at the time of the fall?

- ☐₀ No → Continue
☐₁ Yes → Go to A11

A.9. Were you doing heavy (strenuous) indoor household chores, such as scrubbing floors, sweeping, or vacuuming at the time of the fall?

☐₀ No —————→ **Continue**

☐₁ Yes —————→ **Go to A11**

A.10. Were you working in the yard, such as mowing, raking, gardening, or shoveling snow at the time of the fall?

☐₀ No

☐₁ Yes

A.11. Before you fell, did you faint, pass out, lose consciousness, or have an epileptic seizure or fit?

☐₀ No

☐₁ Yes

A.12. In your own words, please describe exactly what were you doing at the time you fell. Please be specific. [Record complete answer verbatim.]

A.13. At the time that you fell, would you describe your activity level to be strenuous, moderate, or mild? To help you answer, I will read the definition of each level: [read responses 1-3 before participant responds]

☐₁ **Strenuous, where you heart beats fast and you breathe rapidly**

☐₂ **Moderate, where you heart beats a little faster and you breathe a little faster**

☐₃ **Mild, where there is a very small or no increase in heart rate or breathing**

☐₉ Don't know

A.14. Did you need help getting up after the fall?

☐₀ No

☐₁ Yes

A.15. Did you have to lie where you fell until help arrived after the fall?

☐₀ No

☐₁ Yes

A.16. I'm going to read you a list of types of medical treatment on might receive after a fall. From the following list, what type of medical treatment did you need for the fall? *[Read response choices and ask participant to select one; stop reading choices as soon as one has been selected]*

You were admitted to the hospital	<input type="checkbox"/> ₆
You went to the emergency room	<input type="checkbox"/> ₅
You went to the doctor's office for treatment	<input type="checkbox"/> ₄
You were treated by someone with medical training who was NOT a doctor, for example, an <i>EMT</i>	<input type="checkbox"/> ₃
You treated the injury yourself or were treated by a non-medical person	<input type="checkbox"/> ₁
Don't know/don't remember	<input type="checkbox"/> ₉

A.17a. I'm going to read a list of types of injuries that can occur during a fall. For each one, please let me know if the fall caused that type of injury. *[Read list of injuries. For each YES answer, ask A.10b, e.g., if 4-cut=yes, then indicate what body part was cut.]*

	Yes	No
1. broken bone (fracture)	<input type="checkbox"/> ₁	<input type="checkbox"/> ₀
2. sprained or strained joint	<input type="checkbox"/> ₁	<input type="checkbox"/> ₀
3. bruising (contusion)	<input type="checkbox"/> ₁	<input type="checkbox"/> ₀
4. cut (laceration)	<input type="checkbox"/> ₁	<input type="checkbox"/> ₀
5. scrape (abrasion)	<input type="checkbox"/> ₁	<input type="checkbox"/> ₀
6. soreness	<input type="checkbox"/> ₁	<input type="checkbox"/> ₀
8. Other: _____	<input type="checkbox"/> ₁	<input type="checkbox"/> ₀

A.17b. What part(s) of your body were [broken/ sprained/ bruised/ cut/ scraped/ sore/ other] during the fall? *[Code open-ended responses – interviewer does not read response options. Mark all that apply for each type of injury listed in A10a above.]*

	Fracture	Joint	Bruise	Cut	Scrape	Sore	Other
Toe	<input type="checkbox"/> ₁	<input type="checkbox"/> ₁	<input type="checkbox"/> ₁	<input type="checkbox"/> ₁	<input type="checkbox"/> ₁	<input type="checkbox"/> ₁	<input type="checkbox"/> ₁
Ankle	<input type="checkbox"/> ₂	<input type="checkbox"/> ₂	<input type="checkbox"/> ₂	<input type="checkbox"/> ₂	<input type="checkbox"/> ₂	<input type="checkbox"/> ₂	<input type="checkbox"/> ₂
Knee	<input type="checkbox"/> ₃	<input type="checkbox"/> ₃	<input type="checkbox"/> ₃	<input type="checkbox"/> ₃	<input type="checkbox"/> ₃	<input type="checkbox"/> ₃	<input type="checkbox"/> ₃
Leg	<input type="checkbox"/> ₄	<input type="checkbox"/> ₄	<input type="checkbox"/> ₄	<input type="checkbox"/> ₄	<input type="checkbox"/> ₄	<input type="checkbox"/> ₄	<input type="checkbox"/> ₄
Thigh	<input type="checkbox"/> ₅	<input type="checkbox"/> ₅	<input type="checkbox"/> ₅	<input type="checkbox"/> ₅	<input type="checkbox"/> ₅	<input type="checkbox"/> ₅	<input type="checkbox"/> ₅
Hip	<input type="checkbox"/> ₆	<input type="checkbox"/> ₆	<input type="checkbox"/> ₆	<input type="checkbox"/> ₆	<input type="checkbox"/> ₆	<input type="checkbox"/> ₆	<input type="checkbox"/> ₆
Back	<input type="checkbox"/> ₇	<input type="checkbox"/> ₇	<input type="checkbox"/> ₇	<input type="checkbox"/> ₇	<input type="checkbox"/> ₇	<input type="checkbox"/> ₇	<input type="checkbox"/> ₇
Abdomen/stomach	<input type="checkbox"/> ₈	<input type="checkbox"/> ₈	<input type="checkbox"/> ₈	<input type="checkbox"/> ₈	<input type="checkbox"/> ₈	<input type="checkbox"/> ₈	<input type="checkbox"/> ₈
Chest	<input type="checkbox"/> ₉	<input type="checkbox"/> ₉	<input type="checkbox"/> ₉	<input type="checkbox"/> ₉	<input type="checkbox"/> ₉	<input type="checkbox"/> ₉	<input type="checkbox"/> ₉
Finger	<input type="checkbox"/> ₁₀	<input type="checkbox"/> ₁₀	<input type="checkbox"/> ₁₀	<input type="checkbox"/> ₁₀	<input type="checkbox"/> ₁₀	<input type="checkbox"/> ₁₀	<input type="checkbox"/> ₁₀
Arm	<input type="checkbox"/> ₁₁	<input type="checkbox"/> ₁₁	<input type="checkbox"/> ₁₁	<input type="checkbox"/> ₁₁	<input type="checkbox"/> ₁₁	<input type="checkbox"/> ₁₁	<input type="checkbox"/> ₁₁
Wrist	<input type="checkbox"/> ₁₂	<input type="checkbox"/> ₁₂	<input type="checkbox"/> ₁₂	<input type="checkbox"/> ₁₂	<input type="checkbox"/> ₁₂	<input type="checkbox"/> ₁₂	<input type="checkbox"/> ₁₂
Elbow	<input type="checkbox"/> ₁₃	<input type="checkbox"/> ₁₃	<input type="checkbox"/> ₁₃	<input type="checkbox"/> ₁₃	<input type="checkbox"/> ₁₃	<input type="checkbox"/> ₁₃	<input type="checkbox"/> ₁₃
Shoulder	<input type="checkbox"/> ₁₄	<input type="checkbox"/> ₁₄	<input type="checkbox"/> ₁₄	<input type="checkbox"/> ₁₄	<input type="checkbox"/> ₁₄	<input type="checkbox"/> ₁₄	<input type="checkbox"/> ₁₄
Neck	<input type="checkbox"/> ₁₅	<input type="checkbox"/> ₁₅	<input type="checkbox"/> ₁₅	<input type="checkbox"/> ₁₅	<input type="checkbox"/> ₁₅	<input type="checkbox"/> ₁₅	<input type="checkbox"/> ₁₅
Face	<input type="checkbox"/> ₁₆	<input type="checkbox"/> ₁₆	<input type="checkbox"/> ₁₆	<input type="checkbox"/> ₁₆	<input type="checkbox"/> ₁₆	<input type="checkbox"/> ₁₆	<input type="checkbox"/> ₁₆
Head (not face)	<input type="checkbox"/> ₁₇	<input type="checkbox"/> ₁₇	<input type="checkbox"/> ₁₇	<input type="checkbox"/> ₁₇	<input type="checkbox"/> ₁₇	<input type="checkbox"/> ₁₇	<input type="checkbox"/> ₁₇
Other _____	<input type="checkbox"/> ₈₈	<input type="checkbox"/> ₈₈	<input type="checkbox"/> ₈₈	<input type="checkbox"/> ₈₈	<input type="checkbox"/> ₈₈	<input type="checkbox"/> ₈₈	<input type="checkbox"/> ₈₈
Don't know/ remember	<input type="checkbox"/> ₉₉	<input type="checkbox"/> ₉₉	<input type="checkbox"/> ₉₉	<input type="checkbox"/> ₉₉	<input type="checkbox"/> ₉₉	<input type="checkbox"/> ₉₉	<input type="checkbox"/> ₉₉

If more than 1 injury fall was reported in QA.1, ask the entire series of questions (A.2-A.17b) about the second fall. Continue asking the entire series for all injury falls reported that month:

Script if 2 injury falls were reported on QA.1 AND more than 2 falls were reported on calendar:

- A.2.** You also reported falling on mm-dd, mm-dd, and mm-dd (list all dates on which falls are reported, except for the date of the injury fall already reported on).
Considering that date [those dates], and remembering the best that you can, on which of these dates did you have the second fall that caused injury]? [If woman is unsure of exact date of injury fall(s), write DK.]

Injury Fall #2:	___	___	/	___	___	/	___	___
	month			day			year	

The next set of questions will apply specifically to the fall on that date.

Script if 2 injury falls were reported on QA.1 AND only 2 falls were reported on calendar. Also use this script when the # of falls = # of injury falls and you're on the last fall:

- A.2.** You also reported falling on mm-dd (list the other date listed on the falls calendar).
Considering that date [those dates], and remembering the best that you can, on which of these dates did you have the second fall that caused injury]? [If woman is unsure of exact date of injury fall(s), write DK.]

The next set of questions will apply specifically to the fall on that date.

Script if 3 or more injury falls were reported on QA.1:

- A.2.** You reported falling on mm-dd, mm-dd, and mm-dd (list all dates on which falls are reported, except for the date of the injury fall(s) already reported on).
Considering that date [those dates], and remembering the best that you can, on which of these dates did you have the second fall that caused injury]? [If woman is unsure of exact date of injury fall(s), write DK.]

The next set of questions will apply specifically to the fall on that date.

Once all injury falls have been completed, proceed to Section B.

If there were no non-injury falls to report (i.e., if the response to QA.1=the # of falls reported on the calendar), go directly to Section C.

Section B. Non-Injury Falls

If injury falls were reported (P.1=yes):

Now I'd like to ask you about the fall [falls] that did NOT cause an injury.

If no injury falls were reported above (P.1=no):

I'd like to ask you some detailed questions about the fall [falls] you recorded on the calendar.

- B.1. You reported a fall on *mm-dd* (list the first date on the calendar that was not reported above as having caused an injury). The questions I'm going to ask now will apply to that fall.**

Non-Injury Fall #1:	___	___	/	___	___	/	___	___
	month			day			year	

- B.2. Were you at home or away from home at the time of the fall?**

☐₁ At home

☐₂ Away from home

- B.3. Were you inside or outside your home or apartment at the time of the fall?**

☐₁ Inside

☐₂ Outside

- B.4. Were you walking at the time of the fall?**

☐₀ No —————→ **Go to B7**

☐₁ Yes —————→ **Continue**

- B.5. Were you walking for exercise at the time of the fall?**

☐₀ No —————→ **Go to B7**

☐₁ Yes —————→ **Continue**

- B.6. During the walk when you fell, how many minutes were you planning to walk, that is, if you had not fallen?**

 Minutes —————→ **Go to B10**

- B.7. Were you exercising, other than walking for exercise, at the time of the fall?**

☐₀ No —————→ **Continue**

☐₁ Yes —————→ **Go to B10**

B.8. Were you doing heavy (strenuous) indoor household chores, such as scrubbing floors, sweeping, or vacuuming at the time of the fall?

☐₀ No → **Continue**

☐₁ Yes → **Go to B10**

B.9. Were you working in the yard, such as mowing, raking, gardening, or shoveling snow at the time of the fall?

☐₀ No

☐₁ Yes

B.10. Before you fell, did you faint, pass out, lose consciousness, or have an epileptic seizure or fit?

☐₀ No

☐₁ Yes

B.11. In your own words, please describe exactly what were you doing at the time you fell. Please be specific. [Record complete answer verbatim.]

B.12. At the time that you fell, would you describe your activity level to be strenuous, moderate, or mild? To help you answer, I will read the definition of each level: [read responses 1-3 before participant responds]

☐₁ **Strenuous, where you heart beats fast and you breathe rapidly**

☐₂ **Moderate, where you heart beats a little faster and you breathe a little faster**

☐₃ **Mild, where there is a very small or no increase in heart rate or breathing**

☐₉ Don't know

B.13. Did you need help getting up after the fall?

☐₀ No

☐₁ Yes

B.14. Did you have to lie where you fell until help arrived after the fall?

☐₀ No

☐₁ Yes

If there are more falls remaining on the calendar (i.e., more falls that have not yet been reported on), ask the entire series of non-injury questions (B.1-B.14) for each of the remaining falls reported that month.

B.1. You also reported a fall on *mm-dd* (list the next date on the calendar with a fall that was not covered above as either an injury or non-injury fall). The questions I'm going to ask now will apply to that fall.

Non-Injury Fall #2:	___	___	/	___	___	/	___	___
				month			day	year

Section C. For All Types of Falls

C.1. Has this fall . . . (if only one total fall was reported on the calendar)

[Thinking about all the falls you reported on the calendar, have any of the falls . . .]
(if more than one fall was reported on the calendar)

	No	Yes	C.2. For how long? (read response categories)					
			1-2 days	3-5 days	6-7 days	More than a week but less than a month	More than a month	Still limited
a. limited your ability to exercise or walk?	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁ →	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
b. limited your ability to participate in social events?	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁ →	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
c. limited your ability to care for yourself, such as bathing or getting dressed?	<input type="checkbox"/> ₀	<input type="checkbox"/> ₁ →	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆

C.3. Since your fall [falls], how concerned are you about falling during the following activities? (Read each item and response categories)

	Not at all concerned	Somewhat concerned	Fairly concerned	Very concerned
a. Getting dressed or undressed	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
b. Taking a bath or shower	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
c. Getting in or out of a chair	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
d. Going up or down stairs	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
e. Reaching for something above your head or on the ground	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
f. Walking up or down a slope	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
g. Going out to a social event (e.g., religious service, family gathering, or club meeting)	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄

That was my last question. Thank you for your participation in this survey. We appreciate you completing and mailing the falls calendar each month, as well as taking the time to talk to us about the details of your falls. Thank you for your participation in the physical activity part of the WHI Long Life Study. Have a good morning/day/evening/weekend. Goodbye.