

ARE YOU AT RISK OF FALLING?



Falling is not a normal part of ageing. You may not know if you are at risk. Early detection of falls risk is important to avoid injury, keep your independence and maintain your mobility.

If you are over 50 years old, please take a couple of minutes to complete the attached questionnaire. Completing the questionnaire can give you a guide on how safe you are from falling and the areas of your health that might need your attention.

When you have completed the questionnaire, make an appointment to discuss it with your trusted health professional or contact one of the services below.

Use the list below to find organisations that can provide advice or assistance.

| | Metropolitan Adelaide | Regional |
|---|--|---|
| Personal Falls Risk Assessment | Community Geriatric Phone: 1300 0 FALLS (1300 0 32557) | Country Referral Unit Phone: 1800 003 307 |
| Equipment information, including personal alarms | Independent Living Centre Phone: (08) 8266 5260 | Independent Living Centre Phone: 1300 885 886 |
| For Veterans | Rehabilitation Appliances Program (RAP) Department of Veteran Affairs Phone: 133 254 | Rehabilitation Appliances Program (RAP) Department of Veteran Affairs Phone: 1800 555 254 |
| In home support and care services | My Aged Care Phone: 1800 200 422 | |
| For further consumer information | Falls Prevention in SA: Active Ageing Australia Phone: 0437 321 377 fallssa.com.au | |

For more information

Clinical Governance Unit
sahealth.sa.gov.au/safetyandquality
 Telephone: 08 8226 6334

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Government
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SA Health



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If you answered **YES** for more than one of the questions, please discuss this questionnaire during your next appointment with your health professional.

| | YES | NO | UNSURE |
|--|--------------------------|--------------------------|--------------------------|
| My history of falling: | | | |
| I have had two or more falls in the 12 months | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| About my medications: | | | |
| I regularly take sleeping tablets or sedatives or antidepressants | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| I have four or more different types of medications each day | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| About my levels of exercise: | | | |
| I do less than 30 minutes of physical activity in a day on most days of the week (such as housework, gardening or bowls) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| About my balance and walking: | | | |
| I have difficulty getting up from a chair | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| I feel unsteady when walking | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| My foot/feet are painful, or swollen or have bony changes | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| About my health conditions: | | | |
| I have, or previously had the following: | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Problems with my heart, blood pressure or circulation | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| A stroke | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Diabetes | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| A neurological condition that effects movement | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Dizziness or funny turns | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| A need to rush to the toilet | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| A recent major change in my health | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| About my eyesight: | | | |
| I have poor eyesight | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| It has been more than two years since my eyes were tested | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Home environment: | | | |
| My home and garden are not set up so I can do daily activities safely and easily | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |