We would like you to keep a diary about any falls that you might have. Please mark the appropriate box (es) every day to indicate when you have not fallen or when you have almost fallen and/or when you have had an actual fall. Please record the number of falls and near falls you experience in the space provided on the daily calendar. If you have a fall that requires medical attention, please remember to tell us about this at your next study visit.

Falls Data Collection Grid

| **Sunday** | **Monday** | **Tuesday** | **Wednesday** | **Thursday** | **Friday** | **Saturday** |
| --- | --- | --- | --- | --- | --- | --- |
| Date:  No Falls  Near Falls:  Falls: | Date:  No Falls  Near Falls:  Falls: | Date:  No Falls  Near Falls:  Falls: | Date:  No Falls  Near Falls:  Falls: | Date:  No Falls  Near Falls:  Falls: | Date:  No Falls  Near Falls:  Falls: | Date:  No Falls  Near Falls:  Falls: |
| Date:  No Falls  Near Falls:  Falls: | Date:  No Falls  Near Falls:  Falls: | Date:  No Falls  Near Falls:  Falls: | Date:  No Falls  Near Falls:  Falls: | Date:  No Falls  Near Falls:  Falls: | Date:  No Falls  Near Falls:  Falls: | Date:  No Falls  Near Falls:  Falls: |
| Date:  No Falls  Near Falls:  Falls: | Date:  No Falls  Near Falls:  Falls: | Date:  No Falls  Near Falls:  Falls: | Date:  No Falls  Near Falls:  Falls: | Date:  No Falls  Near Falls:  Falls: | Date:  No Falls  Near Falls:  Falls: | Date:  No Falls  Near Falls:  Falls: |
| Date:  No Falls  Near Falls:  Falls: | Date:  No Falls  Near Falls:  Falls: | Date:  No Falls  Near Falls:  Falls: | Date:  No Falls  Near Falls:  Falls: | Date:  No Falls  Near Falls:  Falls: | Date:  No Falls  Near Falls:  Falls: | Date:  No Falls  Near Falls:  Falls: |
| Date:  No Falls  Near Falls:  Falls: | Date:  No Falls  Near Falls:  Falls: | Date:  No Falls  Near Falls:  Falls: | Date:  No Falls  Near Falls:  Falls: | Date:  No Falls  Near Falls:  Falls: | Date:  No Falls  Near Falls:  Falls: | Date:  No Falls  Near Falls:  Falls: |

**Enter Details for Each Fall (use additional pages as necessary)**

Date: Time of Day:  am  pm

Location: Activity:

If you fell while walking, were you wearing any of the following (check all that apply):

Only socks

Socks and shoes/sneakers

Leg braces

Other, please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If you fell while walking, were you using an assistive device (check all that apply):

Cane  Walker  One crutch  Two crutches

Other, please specify:

Injuries Sustained:

If you fell while sitting, transferring or moving in your chair, please check all statements that apply:

I fell while transferring to or from my wheelchair

I fell while transferring into the shower/bath

I fell while moving my wheelchair

When I fell, I was (check all apply):

Being helped by someone else

Using equipment such as a transfer board, hoyer lift, etc.

Using other equipment

Date: Time of Day:  am  pm

Location: Activity:

If you fell while walking, were you wearing any of the following (check all that apply):

Only socks

Socks and shoes/sneakers

Leg braces

Other, please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If you fell while walking, were you using an assistive device (check all that apply):

Cane  Walker  One crutch  Two crutches

Other, please specify:

Injuries Sustained:

If you fell while sitting, transferring or moving in your chair, please check all statements that apply:

I fell while transferring to or from my wheelchair

I fell while transferring into the shower/bath

I fell while moving my wheelchair

When I fell, I was (check all apply):

Being helped by someone else

Using equipment such as a transfer board, hoyer lift, etc.

Using other equipment

Date: Time of Day:  am  pm

Location: Activity:

If you fell while walking, were you wearing any of the following (check all that apply):

Only socks

Socks and shoes/sneakers

Leg braces

Other, please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If you fell while walking, were you using an assistive device (check all that apply):

Cane  Walker  One crutch  Two crutches

Other, please specify:

Injuries Sustained:

If you fell while sitting, transferring or moving in your chair, please check all statements that apply:

I fell while transferring to or from my wheelchair

I fell while transferring into the shower/bath

I fell while moving my wheelchair

When I fell, I was (check all apply):

Being helped by someone else

Using equipment such as a transfer board, hoyer lift, etc.

Using other equipment

## Falls Diary CRF Module Instructions

## General Instructions

This form contains data elements to track patient falls and near falls.

## Specific Instructions

*Please see the Data Dictionary for definitions for each of the data elements included in this CRF Module.*

* Falls Data Collection Grid: – If a near fall or falls is checked, indicate the number.