Appendix 1: Example fall and healthcare utilization calendar

**Could state whether you fell during the following weeks?**

**1. Did you fell in the week of …**

No Yes, Indoors Outdoors Monday April 6th – Sunday April 12th □ □ \_\_\_ times \_\_\_ times Monday April 13th – Sunday April 19th □ □ \_\_\_ times \_\_\_ times   
Monday April 20th – Sunday April 26th □ □ \_\_\_ times \_\_\_ times   
Monday April 27th – Sunday May 3rd □ □ \_\_\_ times \_\_\_ times

**2. In case you’ve fell, how often did you received medical care (e.g. visit to the GP or medical specialist) due to the falling**  \_\_\_ times

**Would you like to answer the following questions concerning your health care utilization of the month APRIL?**

**Be aware:**

Focus only on your own health care utilisation.

**3. Did you had contact with you GP in APRIL?**

Telephone meeting with GP □ No □ Yes, \_\_\_ times

Visit to the GP □ No □ Yes, \_\_\_ times

Home visit GP □ No □ Yes, \_\_\_ times

**4. Did you visit a medical specialist in APRIL?**

Internist □ No □ Yes, \_\_\_ times

Orthopedist □ No □ Yes, \_\_\_ times

Cardiologist □ No □ Yes, \_\_\_ times

Geriatrician □ No □ Yes, \_\_\_ times

Other, namely: \_\_\_ times

**5. Were you admitted to a hospital in APRIL?**

□ No

□ Yes Date: \_\_\_\_\_\_\_ \_\_ Date of discharge: \_\_\_\_\_\_\_\_\_\_\_   
 Department:

Reason:

**Please continue on the next page**

**6**. **Did you had contact with a therapist in APRIL?**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **No** | **Yes** | **Visits to therapist** | **Home visits therapist** |
| **Physiotherapist** |  |  | \_\_\_\_\_\_ times | \_\_\_\_\_\_ times |
| **Occupational therapist** |  |  | \_\_\_\_\_\_ times | \_\_\_\_\_\_ times |
| **Social worker** |  |  | \_\_\_\_\_\_ times | \_\_\_\_\_\_ times |
| **Psychotherapist** |  |  | \_\_\_\_\_\_ times | \_\_\_\_\_\_ times |
| **Other, namely \_\_\_\_\_\_\_\_\_\_\_\_** | | | \_\_\_\_\_\_ times | \_\_\_\_\_\_ times |

**7**. **Did you receive payed or unpaid help in APRIL?**

|  |  |  |  |
| --- | --- | --- | --- |
|  | **No** | **Yes** | **Hours** |
| **Professional home care of nursing** |  |  | \_\_\_\_\_\_ hours |
| **Domestic help (through home care)** |  |  | \_\_\_\_\_\_ hours |
| **Professional domestic help** |  |  | \_\_\_\_\_\_ hours |
| **Help from friend, family, neighbors or volunteers** |  |  | \_\_\_\_\_\_ hours |

**8. Please mark which medical aids (devices) you have purchased in APRIL.**

* No medical aids
* Stick
* Walker
* Adjusted shoes
* Anti-slip mat
* Social alarm system
* Scoot mobile
* Other, namely \_\_\_\_\_\_\_\_

**9. Please mark which adjustments to your house have been made in APRIL.**

* No adjustments
* Anti-slip tiles in shower/bath
* Handles in shower/toilet/bath
* Shower chair
* Bath lift
* Raised toilet
* Lowered bumps
* Railing
* Stair lift
* Other, namely \_\_\_\_\_\_