

How safe are you from falling?

People who are active, and who look after their health and their home, are protecting themselves against the risk of falls.

You may not know if you are at risk. Early detection of falls risk is important to avoid injury and keep your independence and mobility.

If you are over 50 please take a couple of minutes to complete the questionnaire overleaf. It will give you a guide as to how safe you are from falling, and the areas of your health that might need your attention. If you have osteoporosis, your risk of injury maybe higher.

Then take a moment to discuss it with your health professional. Doctors, Nurses, Physiotherapists, Occupational Therapists and Pharmacists can provide advice and assistance to get you the right services.

Think about your home and garden – is it set up so you can do daily activites safely and easily?

You may wish to use the list below to find services and organisations that can provide advice or assistance.

- > To find out what services are in your local area, call your council or Commonwealth Carelink 1800 052 222 (free call)
- > For information about aids and equipment, including personal alarms contact the Independent Living Centre. Phone (08) 8266 5260. Country callers phone 1800 800 523.
- > For a free Veterans home safety assessment, contact HomeFront 1800 801 945
- > For information about having a personal falls risk assessment
 - For Adelaide areas – ask your GP to make a referral to your Local Health Network Falls Prevention Team. Phone 1300 0 FALLS (1300 0 32557).
 - For country areas – contact your local community health service.
- > For information about support and care services in the home, contact Access2HomeCare on 1300 130 551.
- > For further information go to: www.fallssa.com.au

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For more information

Falls and Fall Injury Prevention

Safety and Quality Unit www.sahealth.sa.gov.au/safetyandquality

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Government
of South Australia

SA Health

How safe are you from falling?

My History of falling:	Yes	No	N/A
I have had at least one fall in the last 6 months	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
About my medications:	Yes	No	N/A
I regularly take sleeping tablets or tranquillisers or antidepressants	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I take 4 or more different types of medications each day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
About my levels of exercise:	Yes	No	N/A
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:	Yes	No	N/A
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 deformed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
About my health conditions:	Yes	No	N/A
I have, or previously had the following:			
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"/>
Parkinson's disease	<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:	Yes	No	N/A
I have poor eyesight	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
It has been more than 2 years since my eyes were tested	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If you answered Yes for more than one of the questions, please discuss this questionnaire during your next appointment with your Health Professional.