



ARE YOU AT RISK OF FALLING?

About one third of older people fall each year and half of these people will fall repeatedly. Of those who fall and go to hospital, 80% will have a fracture (most often a hip fracture). Of those people who were living in the community before the fall, approximately 30% will need to live in a nursing home or hostel, due to a decline in walking and/or ability to look after themselves.

To find out whether or not you are at risk of falling, please take a few minutes to complete the following checklist. If you are at risk of falling, please follow the prompts on the other side of the page.

Have you fallen, or nearly fallen, in the last 12 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you go out of the house less often because you are afraid of falling?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you take medicines for nerves, high blood pressure, sleeping problems or depression?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you take more than 3 medications?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you get dizzy?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have a medical condition that affects your walking, balance or memory?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you often have to rush to the toilet?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you unsteady on your feet?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have difficulty turning?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have difficulty with steps or stairs?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you use a walking frame or stick?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you hold onto furniture to keep your balance?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you walk or exercise less than 3 times for 20 minutes per week?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have difficulty getting up from a chair?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Has it been more than 12 months since your last eye check?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you sometimes have difficulty seeing where you are walking?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you ever wear slippers, thongs or slip on shoes?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have a foot condition that affects your walking or balance?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you often miss meals?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is there anything in your garden or home that may make you slip or trip?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have difficulty walking outdoors or in public places?	<input type="checkbox"/> Yes <input type="checkbox"/> No

If you answered 'yes' to most of the questions in the checklist, you may be at risk of falling.

If so, you can:

- Show this checklist to your Doctor – your Doctor can make recommendations and can refer you to other specialists
- Speak to a Physiotherapist or an Occupational Therapist.

For more information, contact:

