Policies and Procedures Manual 2020

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INTRODUCTION

The Community Health and Mobility Partnership (CHAMP) program began in McDowell County, North Carolina in 2009. The purpose of the program is to improve the health of older adults and to decrease their risk of falling. Emphasis is placed on improvements in muscle strength, balance, and mobility by use of an individualized home exercise program based on the Otago Exercise Programme.[1]

The idea for the CHAMP project originated with faculty at the University of North Carolina at Chapel Hill (UNC), and the project became a reality with funding from the Baxter International Foundation, McDowell County government, and the UNC Center for Aging and Health. The original academic-community partnership included the UNC Division of Physical Therapy, the UNC School of Nursing, Western Carolina University Department of Physical Therapy, the Physical Therapist Assistant Program at Caldwell Community College and Technical Institute (CCC&TI), McDowell County Senior Center, and McDowell Technical Community College, as well as representatives from a number of other McDowell County agencies and organizations. Although some of the partnering organizations have changed over time, members of the partnership have always valued the reciprocal learning that takes place between those receiving services, community partners, and interprofessional academic faculty and students. CHAMP is based on the premise that health care students can provide needed services to older adults in the community while at the same time receiving valuable training.

If you are reading this document, you are probably going to be helping at one or more CHAMP events. THANK YOU for your contributions to this program! CHAMP could not exist without the efforts of people like you.

Vicki S. Mercer, PT, PhD

[1]Campbell AJ, Robertson MC. Otago exercise programme to prevent falls in older adults. New Zealand: Otago Medical School, University of Otago; 2003.

POLICIES

COMMUNITY HEALTH AND MOBILITY PARTNERSHIP (CHAMP) POLICIES

1.0 ORGANIZATION

The Community Health and Mobility Partnership (CHAMP) is a falls prevention program that originated in McDowell County in western North Carolina in 2009. A number of academic and community partners work together to provide comprehensive falls risk screening and intervention for older adults and individuals with disabilities. The intervention component of CHAMP is based on the Otago Exercise Programme (OEP) from New Zealand, which is recognized by the Centers for Disease Control as effective in reducing falls among older adults by approximately 35%.

CHAMP events for falls risk screening and intervention are held at community sites that are easily accessible to older adults and individuals with disabilities, such as senior centers and wellness centers. Staff at these centers are key CHAMP partners who assist with public relations, marketing, and participant scheduling for the program.

Initial funding for CHAMP came from the Baxter International Foundation, the UNC Center for Aging and Health, and McDowell County government. The program has been sustained thanks to the volunteer efforts of partnering organizations and individuals. CHAMP provides interprofessional education for physical therapy, physical therapist assistant, nursing, and other health professions students.

1.1 Mission Statement

CHAMP's mission is to prevent falls in community-dwelling older adults and people with disabilities, with a focus on rural and underserved communities. CHAMP seeks to accomplish this mission by:

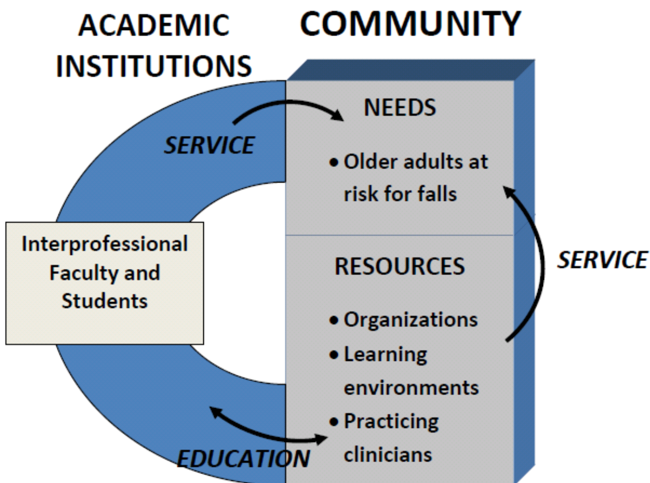
- Providing comprehensive assessment of risk factors for falls
- Implementing evidence-based exercise interventions to improve strength, balance, and mobility
- Providing education and services free of charge to participants
- Communicating with primary care physicians and other members of the health care team, and referring CHAMP participants to other providers as indicated
- Providing service learning opportunities to multiple disciplines
- Fostering intergenerational interaction

We function as a partnership that values:

- Reaching out to adults throughout the region in which the program is implemented, without regard to age, race, gender, socioeconomic status, etc.
- To the greatest extent possible, maintaining fidelity in implementation of Otago and/or other evidence-based intervention(s)
- Ensuring safety and quality of services
- Providing a rich learning environment for interprofessional collaboration and education
- Evaluating methods and outcomes
- Ensuring program sustainability

1.2 Organizational Structure

The overall design for the CHAMP program includes creation of interprofessional teams with expertise in assessing and addressing risk factors for falls. Teams may include physical therapy (PT and PTA), nursing, physician assistant (PA), speech and language pathology, exercise science, and athletic training faculty, students, and clinical personnel. Consistent with the Otago Exercise Programme, physical therapy and nursing are key members of the team, and at least one licensed physical therapist must be present at every CHAMP event. Our proposed model of the process by which an integrated learning experience like CHAMP can benefit academic institutions and communities is shown in the figure below.



1.3 Membership and Voting

CHAMP membership is open to anyone who supports the program's mission. Active members will be those individuals who either provide direct services at CHAMP events or attend at least one CHAMP meeting per year. Active members are eligible to participate in voting on any matters requiring a vote. In order for a vote to occur, at least 2 active members representing each county or region in which CHAMP is implemented must be in attendance. All issues to be voted on shall be decided by a simple majority of those voting members present at the meeting at which the vote takes place.

1.4 County/Regional Teams

Each county or region in which CHAMP is implemented will have a CHAMP team. This team shall include representatives from at least one community-based organization, at least one health organization, and at least one academic institution.

> A community-based organization benefits a constituency in the community with which it works, is governed by people who are served by it, and can demonstrate accountability to the community.
>
> A health organization protects the public's health and benefits a specific constituency.

An academic institution can be public or private, and includes universities and community colleges.

Each CHAMP county/regional team will identify a team leader who will convene team meetings as needed. The team will be responsible for scheduling of CHAMP events in that county/region. This will include ensuring the presence of an adequate number of providers and appropriate supervision of students. County/regional teams also will be responsible for maintaining and storing CHAMP equipment and supplies and for follow-up with physicians and other health care providers in that county/region.

1.5 Executive Committee

The Executive Committee will include 2-3 representatives from each county or region in which the program is implemented. At least 2 members of the Committee will be older adults or individuals with disabilities. The Chair of the Executive Committee will convene regular meeting of the entire CHAMP membership (typically this large group will meet 2 times per year), as well as meetings of the Executive Committee, and will establish an agenda for all meetings. The Chair will oversee the taking of minutes at all meetings.

2.0 PERSONNEL POLICIES FOR CHAMP EVENTS

At least one licensed physical therapist will be present at every CHAMP event. The team leader for the county/region in which the event takes place will serve as the point person for the event, or will designate another individual to serve as point person. This individual will ensure adequate coverage by all disciplines and adequate supervision of students, and will serve as the contact person for CHAMP personnel scheduled to provide services at the event.

2.1 Number of Student Volunteers

- For 1st year PT students, PTA students who are not known to CHAMP providers, and exercise science and athletic training students, the maximum number of students per licensed PT will be 2.
- For 2nd and 3rd year PT students and PTA students who are known to CHAMP providers, the maximum number of students per licensed PT will be 3.
- The maximum for the total number of students working with participants on physical performance testing and exercise instruction will be 6 (if 2 licensed PTs are present) or 8 (if 3 licensed PTs are present).
- For intake, general health assessment, and other CHAMP components, the maximum number of students per supervisor will be 3.
- The total number of students (all disciplines) permitted at a CHAMP event will be determined by the team leader (or his/her designated point person) based on space available and participant volume.

2.2 Knowledge and Skills of Student Volunteers

Prior to providing services at an event, all first-time student volunteers will be oriented to CHAMP policies and procedures and instructed in performance of any assessment and intervention procedures that they will be assisting with. This orientation and instruction will be

provided by one or more faculty members from the partnering academic institution. If a student's faculty member will not be at the event or will not be the primary clinical supervisor at the event, then the faculty member should complete the skills checklist (included in the "Forms" section of this manual) and email the checklist to the supervisor at least one day prior to the event. All student volunteers who will be involved with exercise instruction will be strongly encouraged to complete Otago online training via AHEConnect.

2.3 Evaluation of Student Volunteers

The supervisor for each student volunteer will complete an evaluation of the student's performance on the day of the CHAMP event, using the "Evaluation of Student Performance" form (included in the "Forms" section of this manual). Copies of the completed form will be given to the student and to the student's faculty member. Each student volunteer will also complete an independent self-assessment using the same form.

2.4 Orientation of New Faculty and Clinicians

Prior to providing services at an event, all first-time faculty and clinical volunteers will be oriented to CHAMP policies and procedures. They will complete a self-assessment using the skills checklist (included in the "Forms" section of this manual), and will submit this to the team leader prior to or on the day of the event. All faculty and clinical volunteers who will be involved with exercise instruction should complete Otago online training via AHEConnect.

3.0 PARTICIPANT CONFIDENTIALITY

CHAMP recognizes the confidentiality of participant information and will provide safeguards against loss, destruction, or unauthorized use.

3.1 Confidentiality Agreement

All providers (faculty, students, and clinicians) will sign a confidentiality agreement at every CHAMP event they attend.

3.2 Consent

The participant's written consent will be required for release of information not authorized by law. Participants will sign a consent form when attending a CHAMP event for the first time.

3.3 Management of Participant Information

Participant records will be retained for a period of time not less than 5 years. Paper files will be stored in locked file cabinets and/or file boxes, and will never be left unattended when in use at an event. Electronic files will be encrypted and stored on a password-protected device. De-identified data may be entered in electronic spreadsheets for purposes of program evaluation and/or research.

4.0 INFECTION CONTROL AND SAFETY

4.1 Infection Control

- All CHAMP providers will wash their hands between participant contacts, before providing service at an event, after lunch, after using the restroom, and at other times when hand washing is appropriate.
- CHAMP providers who are ill on the day of an event will not attend the event, and will notify the team leader of their absence as far in advance as possible.
- If a CHAMP participant reports or shows symptoms of acute illness (e.g., nausea, vomiting, fever, sore throat), the participant will be evaluated immediately by nursing, PA, or EMS personnel. The participant will not undergo regular screening or intervention, and his/her appointment will be rescheduled.
- Either disposable pillow cases or easy-to-clean, eco-friendly pillow covers will be used. If disposable pillow cases are used, they will be disposed of after each use.
- Pillow covers and plinths will be sprayed or wiped with disinfectant following each participant usage.

4.2 Safety

Participant safety will be paramount for all CHAMP personnel.

- Personnel will wear name tags at all times at CHAMP events.
- CHAMP personnel should always use their best judgement in determining whether an individual should perform a particular test, or participate in screening at all.
- CHAMP personnel will be knowledgeable of onsite emergency procedures for each event site and will follow these procedures when indicated.
- In the event of l) a fall or injury; 2) respiratory distress; 3) chest pain; 4) dizziness; 5) unusual pain; 6) sudden change in cognitive status; 7) sudden weakness or other signs/symptoms of stroke, the provider will consult with CHAMP nursing, PA, or EMS personnel, summon a physician from an adjacent clinic area, or dial the emergency phone number appropriate to the event site.
- In the event of a fire, the first goal will be to remove all persons from the building. If the fire is confined to one room, the door will be closed.
- In the event of a tornado warning, all CHAMP activities will stop. All persons at the event will be directed to the interior part of the lowest level (a closet, bathroom, or interior hall.)

5.0 FOOTWEAR DISTRIBUTION

The CHAMP footwear distribution program provides quality footwear to seniors who have financial and/or medical necessity. Research has shown that appropriate and specific footwear can significantly decrease an individual's risk of incurring a fall as well as encourage exercise through enhanced ease of mobility.[1]

Licensed professionals involved with footwear distribution will receive specific training in foot care and shoe wear. Each individual participating in the footwear program will be evaluated by a physical therapist.

Each footwear program participant will be asked to attend a footwear assessment and screening. Participants may be required to return for a second assessment, should they encounter new pain or discomfort related to the shoes they have received. Guidelines for these procedures are described below. Participants will be required to sign an informed consent and release of liability waiver.

5.1 Shoe Fitting Appointments

Individuals who wish to participate in the footwear program must do the following:

1. Complete the Footwear Appointment Sign-Up form (see Forms section of this manual) in full.
2. Acknowledge that they DO NOT have diabetes. If they do have diabetes, they are ineligible for the program and should be referred to their primary care provider for an appropriate diabetic footwear referral.
3. Acknowledge that they have not had an unexplained fall in the past year or, if they have fallen, that they have been seen in CHAMP since the fall occurred. If the individual has had a fall and has not been seen in CHAMP, then he/she must be seen in CHAMP before obtaining a footwear appointment.
4. Schedule an appointment to be fitted with and receive shoes.

5.2 Informed Consent and Liability Waiver

All footwear program participants must complete the Informed Consent and Liability Waiver (see Forms section of this manual).

- The provider should explain clearly the terms of the disclaimers and ask the participant to initial or sign all places designated on the form.
- The provider should explain clearly the terms of the waiver, specifically that a participant who experiences any new pain with the shoes should discontinue use of the shoes and seek medical attention as needed.

[1] Doi, T., Yamaguchi, R., Asai, T., Komatsu, M., Makiura, D., Shimamura, M., et al. (2010). The effects of shoe fit on gait in community-dwelling older adults. *Gait & Posture, 32*(2), 274-278. doi:10.1016/j.gaitpost.2010.05.012 [doi]

5.3 Footwear Assessment and Fitting

The examining physical therapist should perform the procedures described below.

- Review the Footwear Appointment Sign-Up form.
  - Confirm that the participant does not have diabetes and, if not a CHAMP participant, has not had an unexplained fall in past year.
  - Identify any medical or physical issues to be considered for shoe selection.
  - Take into consideration any shoe inserts, AFOs, or assistive device(s) used by the participant.
- Pull all participant information and footwear evaluation forms.
- Review the informed consent and release of liability waiver with the participant.
- Complete Footwear Evaluation Form (see Forms section of this manual).
- Inspect participant's feet and note any concerns related to skin integrity.
- Palpate participant's feet and note any sensitive or painful areas.
- Determine the best type and style of shoe for the participant.
- Obtain appropriate shoes (3-4 pairs if available) for participant to try.
  - If needed, refer to the footwear inventory sheet to determine shoe availability and location.
  - Fit each pair of shoes and make notes on each.
  - Assess all areas from the footwear training course for appropriate and secure fit.
  - Select the pair of shoes which has the best FIT, according to the guidelines provided in the footwear distribution training course, and the best FEEL according to participant report.
- With the participant wearing the selected shoes, assess his/her static and dynamic balance.
- Once it has been determined that the participant is safe to ambulate in the shoes, ask him/her to walk continuously for 10 minutes. Provide guarding if necessary.
- After 10 minutes, ask participant to remove the shoes and inspect skin for redness or irritation.
- Document the participant's report of comfort, stability and ease of mobility.

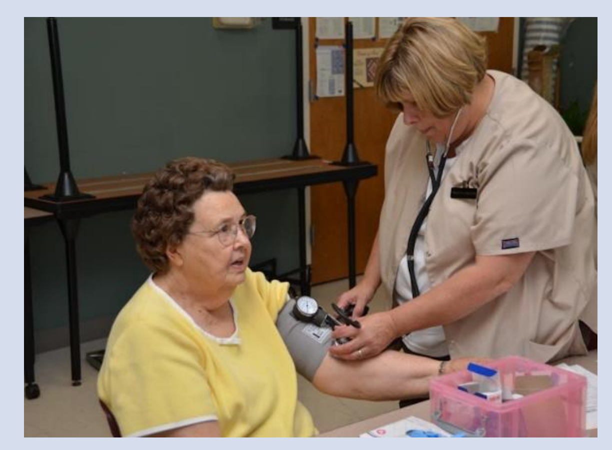
5.4 Follow-Up Secondary to Onset of Pain or Discomfort

- The participant must schedule a return appointment as available.
- The physical therapist should assess and determine whether the new pain or discomfort is caused by the shoe or is from another source.
- The physical therapist should determine whether it is safe and reasonable for the participant to continue using the shoes or whether the shoes can be recycled.
- If the shoes can no longer be used by this participant but can be recycled, then participant can be re-fitted for another pair of shoes. If the shoes cannot be recycled for use by another participant then participant is not eligible for a second pair of shoes.
- If the participant has received a diabetes diagnosis, the participant should return the shoes and should be given information and resources regarding obtaining appropriate diabetic footwear.

INFORMATION FOR PROVIDERS

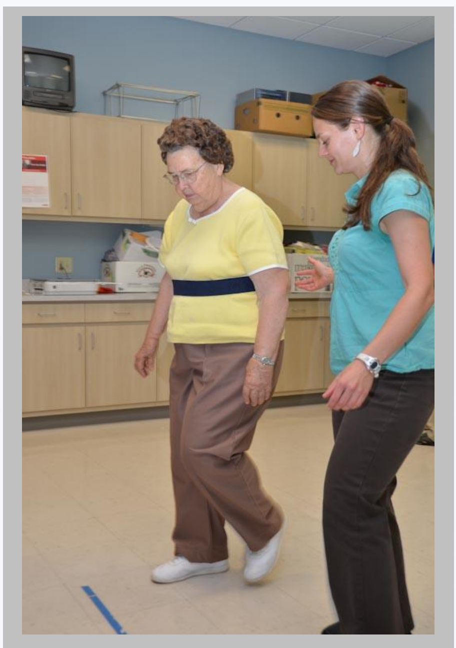
OVERVIEW

At each CHAMP event, participants with concerns about balance and/or mobility undergo comprehensive screening for falls risk factors by a team of nursing/PA, PT, and PTA students, faculty, and clinicians. At some sites, other health professional students and faculty are part of the team. The Assessment Summary Form helps to guide the process, as each participant is assessed for each risk factor.

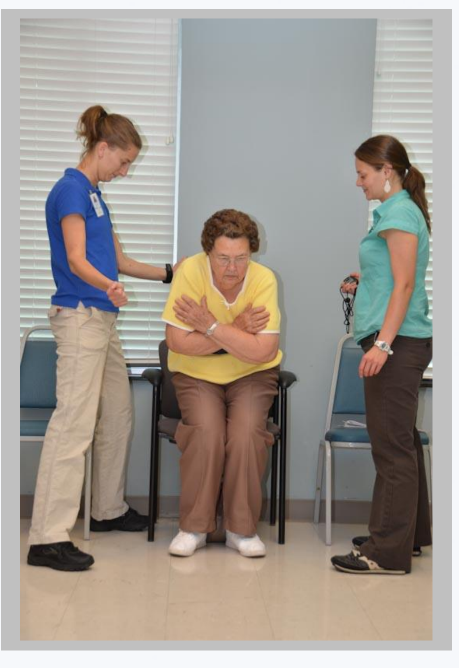


Nursing/PA/EMS personnel focus primarily on medical history; blood pressure assessment in lying, sitting, and standing positions; cognitive screening; medication review; and vision screening. They record their findings on the Assessment Summary Form, which accompanies the participant through each phase of the screening. They also summarize assessment results in face-to-face communications with other members of the team.

Physical therapy (PT and PTA) students, faculty, and clinicians have primary responsibility for performing standardized assessments of upper and lower extremity muscle strength (grip strength, Timed Chair Stands), static balance (Four-Test Balance Scale), and mobility (Timed Up and Go test). They consult with nursing/PA/EMS personnel with regard to any concerns about medical issues, such as possible medication side-effects or interactions that may affect physical performance testing or the interpretation of test results.



Participants who have TUG scores ≥ 12 seconds or demonstrate unsteadiness during TUG testing, are unable to stand on one leg for at least 6.5 seconds, have a history of one or more falls within the last 12 months, or report limiting activities because of concerns about falling are considered to be at increased risk, and are scheduled for follow-up through CHAMP and/or referred to local health care providers.



Those followed through CHAMP are given individualized Otago exercises, instructed in performance of these exercises, and scheduled for at least two follow-up CHAMP appointments. Follow-up visits typically last about 30 minutes, with review of previous recommendations and progression of exercises as appropriate.

COMMUNITY HEALTH AND MOBILITY PARTNERSHIP (CHAMP)
Information for Providers

- The CHAMP screening sites are:

Site	Map
Grove Street Senior Opportunity Center 36 Grove Street Asheville, NC 28801 (828)350-2062	Map: Grove Street Senior Opportunity Center
McDowell County Senior Center 100 Spaulding Road Marion, NC 28752 (828)659-0821	Map: McDowell Senior Center
Quest4Life Wellness Center 1031 Morganton Blvd SW, Suite A Lenoir, NC 28645 (828)758-8753	Map: Quest4Life

- You can sign up to help with CHAMP events on Sign-Up Genius:
  http://www.signupgenius.com/go/30e0c4da8a722a31-champ5
  Please plan to arrive 30 minutes before the screening event, so that everything is ready to go when the first participants arrive. Please plan to stay until the last participant has completed the screening in your area, which may run a little past the official ending time.
- We will meet at the end of the day for a quick wrap-up session.
- At some sites, no screening appointments are scheduled between 12:00 noon and 1:30 pm. This is intended to ensure that all participants and providers will have plenty of time for lunch.
- To protect the participants and your fellow providers, please do not attend the event if you are experiencing symptoms of flu (fever >100 degrees and one or more of the following: stuffy nose, sore throat, cough, weakness, nausea, vomiting, diarrhea, wheezing, or headache) or are otherwise contagious or unable to effectively fulfill your responsibilities as a CHAMP participant. Likewise, participants should not be screened if they are not in good health on the day of screening.
- Please make sure all providers wear nametags/ID badges while at the facility on the day of the event. Not only will this identify providers to the participants and reflect professional competency, it will also help you to know your fellow team members better.
- Participant-entered forms: For those helping with participant intake, please look over the completed forms for missing responses or answers indicating the participant did not understand the question. When these are found, please attempt to clarify the responses with the participant.
- Provider-entered forms: Please remember that others will be reading these forms and may not be familiar with your handwriting.
- If for any reason you or your student(s) is/are unable to be at an event for all or part of your scheduled time, please notify the team leader as far in advance as possible.

INTAKE PROCEDURES

1. Welcome participant and ask how he/she is feeling. If participant has symptoms of illness, fill out appropriate form and send him/her directly to nursing/PA/EMS.
2. Prepare a folder for each participant with the following forms:
    a. Consent
    b. Participant Information
    c. Assessment Summary
    d. Medication and Supplement List
    e. ABC
    f. MMSE
    g. GDS
    h. RAPA
3. Provide ID number (use next in sequence from last CHAMP visit) and record on participant's folder.
4. Ask participant to fill out consent form and participant information form. Review these for completeness and accuracy. Pay special attention to the following:
    a. Boxes are checked for each component that participant consents to.
    b. PCP name and address are provided (make sure participant doesn't put his/her own name and address here).
    c. Question #19 is answered.
    d. Falls history is complete.
5. Administer the following self-report measures in interview format (see instructions for test administration in "Tests and Measures" section of this manual). Enter score for each measure on the first page of the Assessment Summary form.
    a. Activities-specific Balance Confidence scale (ABC) - Add up the ratings for each item and divide by 16 to obtain score.
    b. Mini Mental Status Exam (MMSE) - Add up the points for each item to obtain score.
    c. Geriatric Depression Scale (GDS) - Indicate on the first page of the Assessment Summary form whether you are using the long form or short form. Add up Column A responses to obtain score.
    d. Rapid Assessment of Physical Activity (RAPA). Record both RAPA 1 and RAPA 2 scores.
6. Accompany participant to general health assessment (nursing/PA/EMS), and share any pertinent information from Participant Information form with next CHAMP provider.

PROCEDURES FOR GENERAL HEALTH ASSESSMENT

1. Prepare needed supplies: hand sanitizers, BP cuffs (we have cotton and regular ones, large ones and standard size ones), pillow cover or disposable pillow cases, and sanitizing wipes to clean off plinth after use; gloves are provided if needed
2. Welcome participant and ask participant to use the hand sanitizer.
3. Body weight measurement can be done at this time.
4. Complete the following assessments, and document in the Assessment Summary form:
    a. Medical concerns – review, and identify any areas that CHAMP providers need to be aware of and/or address.
    b. Vital signs - **Protocol for orthostatic blood pressures:**
        i. Have the participant lie supine for a minimum of 3 minutes, and preferably 5 minutes. At the end of this interval, measure blood pressure and pulse (with participant still in supine) and record.
        ii. Instruct participant to stand.
            1. Ask about dizziness, weakness, or visual changes associated with position change. Note diaphoresis or pallor.
            2. Measure blood pressure and pulse immediately after participant comes to standing, and record.
            3. Return to supine position if syncope or near syncope develops.
        iii. Repeat measurement of blood pressure and pulse after participant has been standing for 3 minutes, and record. Have participant sit or lie down if syncope or near syncope develops.
        iv. Refer to Assessment Summary Form and/or laminated chart to determine presence of hypertension or orthostatic hypotension.
    c. Medication review – (see medication review form). Review for high-risk meds, polypharmacy (4+ meds), medication interactions, and difficulty purchasing meds. Refer participants who have difficulty purchasing meds to the Department of Social Services (DSS).
5. Review all findings for **significant health issues that are likely to affect CHAMP testing/intervention**. If the participant has a significant health issue, flag the participant's chart (with red sticker). Use highlighter to highlight the relevant information on the form, and add note next to red sticker indicating reason. Be sure to communicate concerns to the MD as warranted.
6. Guide the participant to the physical performance testing location. **Verbally report any concerns to a licensed physical therapist.**

PROCEDURES FOR BALANCE, MOBILITY, AND STRENGTH TESTING AND EXERCISE PRESCRIPTION

1. Talk with nursing/PA/EMS providers about significant health issues, medical history, and recommendations that participant has been given thus far.
2. Review Participant Information form, paying particular attention to falls history, concerns about balance/falling, and any home safety issues.
3. Review Assessment Summary form, noting results for blood pressure, vision, cognition, and medications.
4. Determine whether any tests should be omitted or modified in light of participant's health issues.
5. Administer the following tests (if appropriate) as described in "Tests and Measures" section (tests can be administered in any order):
    a. Four Stage Balance Test
    b. Grip Strength (record in lbs, and indicate this on the form)
    c. Chair Stands
    d. TUG
6. As each test is completed and recorded, review recommendations with participant.
7. Review ABC scale score and RAPA score in light of participant's performance on physical performance tests, and make recommendations as appropriate.
8. Use decision tree to determine whether participant is at increased risk for falls.
9. If participant is at increased risk:
    a. Select appropriate exercises for participant, recording your recommendations on the Exercise Prescription form.
    b. If appropriate, give participant ankle cuff weights, and instruct him/her in correct amount of weight (if any) to use. Participants may benefit from practicing donning and doffing the cuff, even without any weight in it.
    c. Instruct participant in how to perform the exercises.
    d. Give the participant an exercise/falls calendar that will cover at least six months after the initial CHAMP visit. Ask the participant to record his/her exercise and walking time each day, and to indicate either "yes" or "no" to the question of whether he/she had a fall that day.
    e. Talk with the participant about date for follow-up appointment, and add this on the Assessment Summary form.
    f. Explain to the participant that he/she will be receiving a follow-up call from a health professional student to see how the participant is doing and to answer any questions. Note that this call may come from 919 or other area code.
    g. Remind participant to bring exercise/falls calendar to the next appointment.
10. If participant is NOT at increased risk:
    a. Give participant a copy of the standard exercises.
    b. Provide exercise instruction to participant.
    c. Make a copy of the Assessment Summary form and give to the participant if requested.

FORMS: ASSESSMENT SUMMARY

Community Health and Mobility Partnership (CHAMP)

Assessment Summary Form 2020

Participant ID: ___________________

Year of Initial Visit to CHAMP: _______________ **Height:** [1st visit] _______ft _______in.

CHAMP Visit #	1	2	3	4	5
Risk Factor	**Date:**	**Date:**	**Date:**	**Date:**	**Date:**
ABC Scale score (<67%)	%	%	%	%	%
Mini Mental Status Exam Score Cognitive impairment if ≤24					
Geriatric Depression Scale – **long** form or **short** form (circle)					
RAPA 1 score					
RAPA 2 score					
Weight	#	#	#	#	#
Blood Pressure and Pulse **[Circle any pulse that is irregular]**					
Supine 5 minutes	/ mm Hg	/ mm Hg	/ mm Hg	/ mm Hg	/ mm Hg
Pulse	bpm	bpm	bpm	bpm	bpm
Initial standing	/ mm Hg	/ mm Hg	/ mm Hg	/ mm Hg	/ mm Hg
Pulse	bpm	bpm	bpm	bpm	bpm
Standing 3 minutes	/ mm Hg	/ mm Hg	/ mm Hg	/ mm Hg	/ mm Hg
Pulse	bpm	bpm	bpm	bpm	bpm
Oxygen saturation	%	%	%	%	%
Postural hypotension? (also note if >20 bpm increase in pulse from supine to standing)					
Dizziness with positional change?					
Medication Concerns					
4+ medications?					
High-risk medications?					
Difficulty purchasing medications?					
Other medication concerns? (e.g., reports problems swallowing meds?)					
Vision Concerns					
Date of last eye exam____________ Wears glasses? Multifocal lenses?					
Difficulty reading small print?					
Reports other vision problems?					

Community Health and Mobility Partnership (CHAMP)

Assessment Summary Form 2020

Participant ID: ___________________

CHAMP Visit #	1	2	3	4	5
Risk Factor	**Date:**	**Date:**	**Date:**	**Date:**	**Date:**
Balance Concerns Four Stage Balance Test – record times to nearest 0.1 sec					
Feet together to 10 sec max	_______ sec	_______ sec	_______ sec	_______ sec	_______ sec
Semi-tandem to 10 sec max	_______ sec	_______ sec	_______ sec	_______ sec	_______ sec
Tandem to 10 sec max	_______ sec	_______ sec	_______ sec	_______ sec	_______ sec
*At risk if less than 6.5 sec. One leg stand to 30 sec max	_______ sec	_______ sec	_______ sec	_______ sec	_______ sec
Strength Concerns					
Grip Strength in lbs. (mean of 3 trials) – optional after 1st visit	R: R: R: Mean: L: L: L: Mean:	R: R: R: Mean: L: L: L: Mean:	R: R: R: Mean: L: L: L: Mean:	R: R: R: Mean: L: L: L: Mean:	R: R: R: Mean: L: L: L: Mean:
Chair Stands – Number completed in 30 sec without UEs					
Chair Stands – Modification needed? Describe, and enter number of stands					
Mobility Concerns					
Timed Up and Go (TUG) [allow 1 practice trial, then 2 test trials]	1: 2: MEAN:	1: 2: MEAN:	1: 2: MEAN:	1: 2: MEAN:	1: 2: MEAN:
Instability during TUG?					
*Risk of Fall? (mean ≥ 12 sec, or instability noted)					
List any assistive device(s)					
Is participant wearing appropriate footwear? Difficulty purchasing?					
Follow Up					
Since your most recent visit to CHAMP, rate your performance in following exercise recommendations: 1 Poor 2 Borderline 3 Satisfactory 4 Good 5 Outstanding					
In the past 7 days, how many days have you done your exercises? (0-7) (Review falls/exercise calendar)					
Have you had a fall since your most recent visit to CHAMP? How many? Were you hurt? Did you call EMS or go to the hospital Emergency Department? Other information? (Review falls/exercise calendar)		# Falls ____ Injury Y/N EMS, ED Y/N	# Falls ____ Injury Y/N EMS, ED Y/N	# Falls ____ Injury Y/N EMS, ED Y/N	# Falls ____ Injury Y/N EMS, ED Y/N

Community Health and Mobility Partnership (CHAMP)

Assessment Summary Form 2020

Participant ID: ___________________

Classification of Blood Pressure for Adults Aged 18 and Older (2017 ACSM guidelines – Whelton, PK et al)

BP Category	SBP		DBP
Normal	<120 mm Hg	and	<80 mm Hg
Elevated	120–129 mm Hg	and	<80 mm Hg
Hypertension			
Stage 1	130–139 mm Hg	or	80–89 mm Hg
Stage 2	≥140 mm Hg	or	≥90 mm Hg

*Individuals with SBP and DBP in 2 categories should be designated to the higher BP category.

Postural hypotension: For evaluation of postural hypotension, **subtract BP in supine from BP in standing after 3 minutes**. Postural hypotension is "*a systolic blood pressure decrease of at least 20 mm Hg or a diastolic blood pressure decrease of at least 10 mm Hg within three minutes of standing*".* If participant has drop in BP that resolves within 3 minutes, this is **not** considered postural hypotension, but should be addressed (e.g., recommend slow transitions). Also note if participant has heart rate increase of more than 20 bpm with transition to standing.
*Consensus statement on the definition of orthostatic hypotension, pure autonomic failure, and multiple system atrophy. The Consensus Committee of the American Autonomic Society and the American Academy of Neurology. Neurology 1996;46:1470.

VISIT #1 Date:

Summary of today's assessment:

Does participant need to be followed? Yes No (circle)
Participant should be followed for any of the following: one leg stand < 6.5 sec; TUG mean ≥ 12 sec or instability on the TUG; history of any fall in past year; participant limits activity because of fear of falling (consider MOB).

Return date: _____________ If followed, **participant should receive exercise/falls calendar** and should be reminded that he/she will receive follow-up phone call that may be from 919 or other area code.

Check here if exercise/falls calendar was given. ☐ **Screener signatures:** ____________________________________

Check here if exercises were given. ☐ ____________________________________

____

____

VISIT #2 Date:

Summary of today's assessment:

Return date: _____________

Check here if exercises were given. ☐ **Screener signatures:** ____________________________________

Check here if exercises were modified. ☐ ____________________________________

Check here if exercise/falls calendar was reviewed. ☐ ____________________________________

____

Community Health and Mobility Partnership (CHAMP)

Assessment Summary Form 2020

Participant ID: ___________________

Visit #3 Date: **Summary of today's assessment:**   **Return date:** _____________ Check here if exercises were given. ☐ **Screener signatures:** _____________________________________ Check here if exercises were modified. ☐ _____________________________________ Check here if exercise/falls calendar was reviewed. ☐ _____________________________________ _____________________________________
Visit #4 Date: **Summary of today's assessment:**   **Return date:** _____________ Check here if exercises were given. ☐ **Screener signatures:** _____________________________________ Check here if exercises were modified. ☐ _____________________________________ Check here if exercise/falls calendar was reviewed. ☐ _____________________________________ _____________________________________
Visit #5 Date: **Summary of today's assessment:**   **Return date:** _____________ Check here if exercises were given. ☐ **Screener signatures:** _____________________________________ Check here if exercises were modified. ☐ _____________________________________ Check here if exercise/falls calendar was reviewed. ☐ _____________________________________ _____________________________________

Community Health and Mobility Partnership (CHAMP)

Assessment Summary Form 2020 for Follow-Up Visits (Visits #6 - #10)

Participant ID: ____________________

Year of Initial Visit to CHAMP: _______________ **Height:** [1st visit] _______ft _______in.

CHAMP Visit #		6	7	8	9	10
Risk Factor		**Date:**	**Date:**	**Date:**	**Date:**	**Date:**
ABC Scale score (<67%)		%	%	%	%	%
Weight		#	#	#	#	#
Blood Pressure and Pulse [Circle any pulse that is irregular]						
Sitting		/ mm Hg	/ mm Hg	/ mm Hg	/ mm Hg	/ mm Hg
Pulse		bpm	bpm	bpm	bpm	bpm
Oxygen saturation		%	%	%	%	%
Dizziness with positional change?						
Medication Concerns						
Any medication changes or other medication concerns?						
Vision Concerns						
Date of last eye exam____________ Any new concerns about vision?						
Balance Concerns Four Stage Balance Test – record times to nearest 0.1 sec						
Feet together to 10 sec max		_______ sec	_______ sec	_______ sec	_______ sec	_______ sec
Semi-tandem to 10 sec max		_______ sec	_______ sec	_______ sec	_______ sec	_______ sec
Tandem to 10 sec max		_______ sec	_______ sec	_______ sec	_______ sec	_______ sec
*At risk if less than 6.5 sec. One leg stand to 30 sec max		_______ sec	_______ sec	_______ sec	_______ sec	_______ sec
Strength Concerns						
Grip Strength in lbs. (mean of 3 trials) – optional after 1st visit		R:	R:	R:	R:	R:
		R:	R:	R:	R:	R:
		R:	R:	R:	R:	R:
		Mean:	Mean:	Mean:	Mean:	Mean:
		L:	L:	L:	L:	L:
		L:	L:	L:	L:	L:
		L:	L:	L:	L:	L:
		Mean:	Mean:	Mean:	Mean:	Mean:
Chair Stands	Number completed in 30 sec					
	Modification needed? Describe, and enter number of stands					

Community Health and Mobility Partnership (CHAMP)

Assessment Summary Form 2020 for Follow-Up Visits (Visits #6 - #10)

Participant ID: ___________________

CHAMP Visit #	6	7	8	9	10
Risk Factor	**Date:**	**Date:**	**Date:**	**Date:**	**Date:**
Mobility Concerns					
Timed Up and Go (TUG) [allow 1 practice trial, then 2 test trials]	1: 2: MEAN:	1: 2: MEAN:	1: 2: MEAN:	1: 2: MEAN:	1: 2: MEAN:
Instability during TUG?					
*Risk of Fall? (mean ≥ 12 sec, or instability noted)					
List any assistive device(s)					
Is participant wearing appropriate footwear? Difficulty purchasing?					
Follow Up					
Since your most recent visit to CHAMP, rate your performance in following exercise recommendations: 1 Poor 2 Borderline 3 Satisfactory 4 Good 5 Outstanding					
In the past 7 days, how many days have you done your exercises? (0-7)					
Have you had a fall since your most recent visit to CHAMP? How many? Were you hurt? Did you call EMS or go to the hospital Emergency Department? Other information?	# Falls ____ Injury Y/N EMS, ED Y/N	# Falls ____ Injury Y/N EMS, ED Y/N	# Falls ____ Injury Y/N EMS, ED Y/N	# Falls ____ Injury Y/N EMS, ED Y/N	# Falls ____ Injury Y/N EMS, ED Y/N

VISIT #6 Date:

Summary of today's assessment:

Return date: ____________

Check here if exercises were given. ☐

Screener signatures: ___________________________________

____

Check here if exercises were modified. ☐

Check here if falls/exercise calendar was reviewed. ☐

VISIT #7 Date:

Summary of today's assessment:

Return date: ____________

Check here if exercises were given. ☐

Screener signatures: ___________________________________

____

Check here if exercises were modified. ☐

Check here if falls/exercise calendar was reviewed. ☐

Assessment Summary Form 2020 for Follow-Up Visits (Visits #6 - #10)

Participant ID: ___________________

Visit #8 Date:
Summary of today's assessment:

Return date: ____________

Check here if exercises were given. ☐ **Screener signatures:** ___________________________________

Check here if exercises were modified. ☐ ___________________________________

Check here if falls/exercise calendar was reviewed. ☐

Visit #9 Date:
Summary of today's assessment:

Return date: ____________

Check here if exercises were given. ☐ **Screener signatures:** ___________________________________

Check here if exercises were modified. ☐ ___________________________________

Check here if falls/exercise calendar was reviewed. ☐

Visit #10 Date:
Summary of today's assessment:

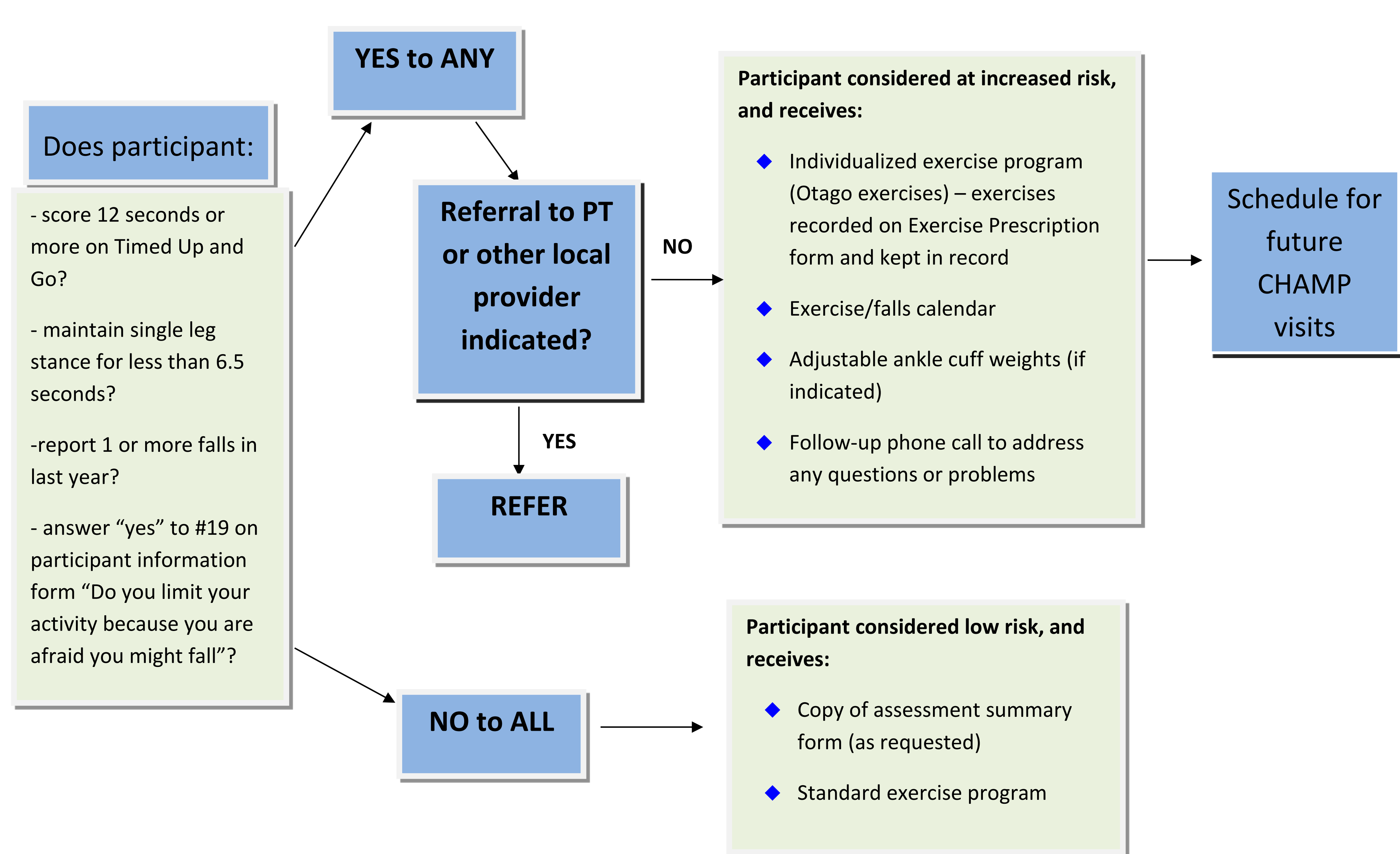
Return date: ____________

Check here if exercises were given. ☐ **Screener signatures:** ___________________________________

Check here if exercises were modified. ☐ ___________________________________

Check here if falls/exercise calendar was reviewed. ☐

Algorithm for Risk Identification and Recommendations for CHAMP



FORMS: PARTICIPANT CONSENT AND SELF-REPORT

Consent Form

Description of screening activities

During the course of the screening session, health profession students and their supervisors will have you complete questionnaires and talk with you to assess the following aspects of your health and function:

1. Health history and current conditions (includes medical conditions, blood pressure, and pulse)
2. Unsteadiness and falling
3. Vision
4. Medication
5. Home safety, use of walking devices
6. Depression
7. Physical activity

You will also be asked to perform physical tasks that require getting up from a chair, walking, and balancing.

Trained health personnel will talk with you about things you can do to improve your balance and reduce your risk of falling. At the conclusion of your screening session, you will be provided with a summary of information about your performance and specific exercise recommendations. Your screening session will take approximately 1 hour.

If you have any medical condition in which physical activity is contraindicated, including uncontrolled hypertension, chest pain, shortness of breath, or pain that is worsened by physical activity, you should not participate.

Benefits of participation

You will benefit from this screening program by receiving individualized feedback from trained health personnel about your general health, balance, mobility, and risk of falling. You will also receive recommendations to help you improve your balance and reduce your risk of falling and other health-related concerns.

Risks of participation

During this screening program, you will be asked to perform several mobility skills, such as getting up from a bed and a chair, walking, and balancing. Performance of these skills involves minimal risk of fatigue or loss of balance. To minimize the risk of loss of balance or falling, trained health personnel will remain next to you during the tests and will provide assistance should you become unsteady. You may rest at any point during the screening process.

Follow Up

Depending on your screening results, you may be referred to other health care providers or scheduled to attend subsequent CHAMP events to check on your progress. We also will follow up with you to see whether you need help with any of our recommendations or with accessing community services.

Protecting your privacy

The information gathered from this event will be kept confidential and will only be available to your physician and the staff participating in this screening event. Otherwise, the results of this screening will be reported only in aggregate form. You will not be identified in any way.

Statement of consent

I, _____________________________, have read and understand the above information. I have freely chosen to participate in this free screening event. By voluntarily participating in today's screening, I accept all risks associated with it. I understand that this screening should in **no way** replace an annual physical/check-up provided by a physician, and will only address certain specific health needs. I understand that the persons involved in this screening will maintain confidentiality of the results in accordance with federal and state laws. All of my questions have been answered satisfactorily. I consent to:

- ☐ Participation in this screening event
- ☐ Being contacted by telephone after the screening event
- ☐ CHAMP staff sharing the findings from this screening event with my primary care provider.
  My primary care physician or other provider is:
  Name:

  My primary care physician's contact information is:
  Address:
  Phone:
  Fax:

______________________________ ______________________
Participant's Printed Name Date

______________________________ ______________________
Participant's Signature Date

______________________________ ______________________
Witness Signature Date

COMMUNITY HEALTH AND MOBILITY PARTNERSHIP (CHAMP)

Photograph/Information Release Authorization Form

Participant's name: ___________________________

Photography/Videography Release:

I understand that I may be photographed or videotaped during CHAMP events, and that these images may be used in publications and/or presentations by CHAMP or any of its partnering organizations. Images may be published in various media, including newsletters, websites, Facebook pages, local newspapers, brochures, and fliers.

I grant permission to CHAMP to copyright, publish, exhibit, and distribute all or any portions of the photography or video recording representing me or pertaining to me for use in any of its educational, research, or public service purposes or for any other purpose related to its educational mission. This form releases CHAMP, its partnering organizations, and its volunteers from any claims arising from the use of such images.

I understand and agree that I will not be identified by name in printed, internet or broadcast information that might accompany the photograph or image of me.

Signature of Participant:	
Printed Name:	**Date:**

Witness signature _________________________________ Date: _______________

Witness printed name: __________________________________

PARTICIPANT INFORMATION

Please print your responses and complete all 3 pages. Thank you.

Have you participated in past CHAMP screenings? ☐ YES ☐ NO

1. Name________________________________
2. Gender: ☐ Male ☐ Female
3. Phone Number__________________________
4. Address____
5. Birth date____/____/____
6. Age________
7. Height_________
8. Weight_________
9. Ethnicity: Do you consider yourself to be Hispanic or Latino? (See definition below.) Select one.

Hispanic or Latino. A person of Mexican, Puerto Rican, Cuban, South or Central American, or other Spanish culture or origin, regardless of race. The term, "Spanish origin," can be used in addition to "Hispanic or Latino."

☐ **Hispanic or Latino**

☐ **Not Hispanic or Latino**

10. Race: What race do you consider yourself to be? Select one or more of the following.

☐ ***American Indian or Alaska Native.*** A person having origins in any of the original peoples of North, Central, **or** South America, and who maintains tribal affiliation or community attachment.

☐ ***Asian.*** A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian **subcontinent**, including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.

☐ ***Black or African American.*** A person having origins in any of the black racial groups of Africa. Terms such as "Haitian" or "Negro" can be used in addition to "Black" or African American."

☐ ***Native Hawaiian or Other Pacific Islander.*** A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or **other** Pacific Islands.

☐ ***White.*** A **person** having origins in any of the original peoples of Europe, the Middle East, or North Africa.

☐ Check here if you do not wish to provide some or all of the above information.

11. What is the highest degree you obtained? (check one)

☐ Less than a high school diploma or GED

☐ High school diploma or GED

☐ Associate degree

☐ Bachelor's degree

☐ Graduate degree

12. Have you ever had any of the following conditions? (check all that apply)

☐	Heart attack Date:	☐	Cancer Type:_______________ When: ________ Any current treatment : ______________
☐	Heart Disease	☐	Osteoporosis
☐	High Blood Pressure	☐	Fracture (broken bone) Which bone? __________ When: _______ Treatment: ________________
☐	Chest pain	☐	Stroke When?__________ Which side? ________
☐	Arthritis Where? _________	☐	Neurologic conditions, such as Parkinson's Disease
☐	Foot disorders or pain (e.g. bunions, heel spur)	☐	Fainting spells
☐	Problem with vision that is not corrected by glasses	☐	Feeling blue or depressed
☐	Diabetes (high sugar)	☐	Difficulty sleeping
☐	Neuropathy (numbness in hands or feet)	☐	Incontinence (bladder or bowel) or bladder leaking
☐	Dizziness	☐	Shortness of breath When walking or exercising _____ At rest ______
☐	Other: Please specify		

13. Do you live: (check one)
   - ☐ Alone without assistance
   - ☐ With a spouse, other relative, or friend
   - ☐ Alone in your own residence, with assistance from a friend, housekeeper, or personal aide

14. Do you have an emergency call device (e.g., Lifeline)? ☐ YES ☐ NO

15. Do you go up/down any steps to enter your home? ☐ YES ☐ NO
    If yes, is there a handrail? ☐ YES ☐ NO

16. Do you go up/down any steps once you are inside your home? ☐ YES ☐ NO
    If yes, is there a handrail? ☐ YES ☐ NO

17. Do you use any devices for safety or to assist you in the bathroom ☐ YES ☐ NO
    If yes, please specify:
    ☐ grab bar(s) ☐ raised toilet seat
    ☐ shower or tub chair ☐ long-handled sponge
    ☐ other (specify: ______________________________)

18. Have you experienced a fall (defined as unintentionally coming to rest on the ground or other lower surface) over the past 12 months? ☐ YES ☐ NO

    If yes, how many falls? _______

    How many of these falls resulted in injury? ________

    How many of these falls with injury required evaluation by a physician? _______

    Nature of any injuries? ____________________

19. Do you limit your activities because you are afraid you might fall? ☐ YES ☐ NO
    Rate your fear of falling on a 0 – 10 scale, with 10 being greatest fear ________

20. Do you wear sturdy walking shoes with low or no heels? ☐ YES ☐ NO

21. Do you have difficulty purchasing shoes that are good quality and fit you well? ☐ YES ☐ NO

The following questions refer to how you are feeling TODAY

22. Do you have any pain today? ☐ YES ☐ NO
    If YES, where? ____________ Is your pain increased by physical activity? ☐ YES ☐ NO

    Rate your pain on a 0 – 10 scale, with 10 being worst pain ________
    ____

23. Have you had any signs of problems with your blood pressure today (such as dizziness or headache)? ☐ YES ☐ NO
    If YES, please describe.

24. Have you had any signs of problems with your blood sugar today? ☐ YES ☐ NO
    If YES, please describe.

25. Have you had any surgical or medical procedures in the past 6 months? ☐ YES ☐ NO
    If YES, please describe.

26. Do you have any concerns that you may not be able to participate in the testing today?

CHAMP Medication & Supplement List

A pharmacist, nurse or other health professional will review your medications. Please list all prescription medications, over-the-counter medicines, vitamins or other nutritional supplements, pain relievers, antacids, laxatives, and herbal remedies that you are taking or have recently taken.

Name: ________________________________ **Date:** ___________ **Participant ID:**_______

Date/ Initials	Name of Medication (example: Vasotec)	Dose (example: one 5 mg tablet)	When Taken (example: twice a day – 7am & 7pm)

Other Recommendations:____

____

____

____

Signature of Pharmacist or Health Care Provider reviewing Medication

____

- If there are documented interactions between medications, please note with an asterisk (*) and draw lines to connect the medications with interactions.
- If a medication is associated with an increased risk for falls based on the AGS 2019 Beer's Criteria (e.g., benzodiazepines, anticholinergics, opioids, sedative-hypnotics), please indicate this with hashtag **(#)** in the date column. Zolpidem (Ambien) is an example of a medication associated with high fall risk. ***Fax all medication lists to the PCP, noting any medication concerns on this form.***

FORMS: TESTS AND MEASURES (WITH INSTRUCTIONS FOR ADMINISTRATION)

The Activities-specific Balance Confidence (ABC) Scale*

Administration

The ABC will be administered via personal interview. An enlarged version of the rating scale on an index card will facilitate interviews. Each respondent should be queried concerning his/her understanding of the instructions, and probed regarding difficulty answering any specific items. The respondent should provide a number printed on the scale for each item (for example, "85%" is not on the scale, so the participant should be asked to choose either 80% or 90%). The administrator should repeat the phrase "How confident are you that you can maintain your balance and remain steady when you…" for every item.

Instructions to Respondents

"For each of the following, please indicate your level of confidence in doing the activity without losing your balance or becoming unsteady by choosing one of the percentage points on the scale from 0% to 100%. If you **do not currently do** the activity in question, try to imagine how confident you would be if you had to do the activity. If you **normally** use a walking aid to do the activity or hold onto someone, rate your confidence as if you were using these supports. If you have any questions about answering any of the items, please ask me."

Instructions for Scoring

Total the ratings (possible range = 0 to 1600) and divide by 16 (or the number of items completed) to get each person's ABC score. If a person qualifies his/her response to items #2, #9, #11, #14, or #15 (different ratings for "up" vs "down" or "onto" vs "off"), solicit separate ratings and use the **lowest** confidence rating of the two (as this will limit the entire activity, e.g, likelihood of using stairs). Total scores can be computed if at least 12 of the items are answered. Note: internal confidence (alpha) does not decrease appreciably with the deletion of item # 16--icy sidewalks--for administration in warmer climates (Myers et al.'98).

Powell LE & Myers AM. The Activities-specific Balance Confidence (ABC) Scale. *J Gerontol Med Sci* 1995; 50 (1):M28-34.

Myers AM, Powell LE, Maki BE et al. Psychological indicators of balance confidence: Relationship to actual and perceived abilities. *J Gerontol Med Sci* 1996; 51A: M37-43.

Myers AM, Fletcher PC, Myers AH & Sherk W. Discriminative and evaluative properties of the Activities-specific Balance Confidence (ABC) Scale. *J Gerontol Med Sci* 1998; 53A: M287-M294.

Myers AM. *Program Evaluation for Exercise Leaders.* Champaign, IL: Human Kinetics.

Participant ID number: _____ Date: _____

The Activities-specific Balance Confidence (ABC) Scale*

Instructions to Participants:

For each of the following, please indicate your level of confidence in doing the activity without losing your balance or becoming unsteady by choosing one of the percentage points on the scale from 0% to 100%. If you do not currently do the activity in question, try to imagine how confident you would be if you had to do the activity. If you normally use a walking aid to do the activity or hold onto someone, rate your confidence as if you were using these supports. If you have any questions about answering any of these items, please ask the administrator.

The Activities-specific Balance Confidence (ABC) Scale*

For each of the following activities, please indicate your level of self-confidence by choosing a corresponding number from the following rating scale:

0%	10	20	30	40	50	60	70	80	90	100%
no confidence										completely confident

"How confident are you that you will not lose your balance or become unsteady when you…

1. …walk around the house? ____%
2. …walk up or down stairs? ____%
3. …bend over and pick up a slipper from the front of a closet floor? ____%
4. …reach for a small can off a shelf at eye level? ____%
5. …stand on your tiptoes and reach for something above your head? ____%
6. …stand on a chair and reach for something? ____%
7. …sweep the floor? ____%
8. …walk outside the house to a car parked in the driveway? ____%
9. …get into or out of a car? ____%
10. …walk across a parking lot to the mall? ____%
11. …walk up or down a ramp? ____%
12. …walk in a crowded mall where people rapidly walk past you? ____%
13. …are bumped into by people as you walk through the mall? ____%
14. … step onto or off an escalator while you are holding onto a railing? ____%
15. … step onto or off an escalator while holding onto parcels such that you cannot hold onto the railing? ____%
16. …walk outside on icy sidewalks? ____%

TOTAL ____

SCORE = TOTAL ÷ 16 ____

*Powell, LE & Myers AM. The Activities-specific Balance Confidence (ABC) Scale. J Gerontol Med Sci 1995; 50(1): M28-34. Reprinted with permission from Oxford University Press.

Mini-Mental State Examination*

Orientation	1. Ask for the Date. Then ask specifically for parts omitted, eg, “Can you also tell me what season it is?” Score one point for each correct answer. 2. Ask in turn, “Can you tell me the name of this building?” (town, county, etc.) Score one point for each correct answer.
Registration	Ask the participant if you may test his/her memory. Then say the names of 3 unrelated objects, clearly and slowly, about one second for each. After you have said all 3, ask the participant to repeat them. This first repetition determines his/her score (0-3) but keep saying them until he/she can repeat all 3, up to 6 trials. If all 3 are not eventually learned, recall cannot be meaningfully tested.
Attention and Calculation	Ask the participant to spell the word “world” backwards. The score is the numbers of letters in correct order (eg, DLROW=5; DLRW=4; DLORW, DLW=3; OW=2; DRLWO=1).
Recall	Ask the participant if he/she can recall the 3 words you previously asked him/her to remember. Score 0 – 3.
Language	***Naming:*** Show the participant a wristwatch and ask him/her what it is. Repeat for pencil. Score 0 – 2.
	Repetition: Ask the participant to repeat the sentence after you. Allow only one trial. Score 0 – 1.
	3-stage command: Give the participant a piece of plain blank paper and repeat the command. Score 1 point for each part correctly executed.
	Reading: On a blank piece of paper print the sentence, “Close your eyes,” in letters large enough for the participant to see clearly. Ask him/her to read it and do what it says. Score 1 point only if he actually closes his eyes.
	Writing: Give the participant a blank piece of paper and ask him/her to write a sentence for you. Do not dictate a sentence; it is to be written spontaneously. It must contain a subject and verb and be sensible. Correct grammar and punctuation are not necessary.
	Copying: On a clean piece of paper, draw intersecting pentagons, each side about 1 in., and ask him/her to copy it exactly as it is. All 10 angles must be present and 2 must intersect to score 1 point. Tremor and rotation are ignored.

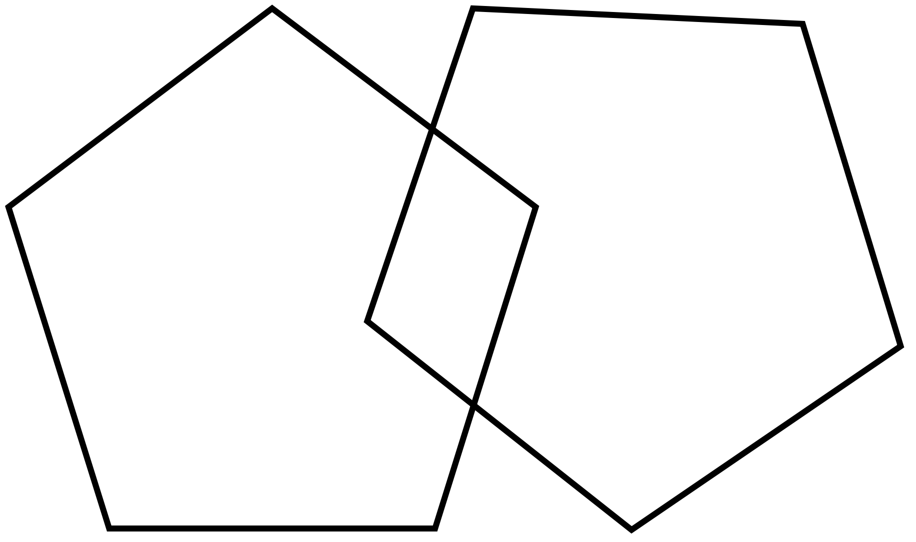
*Folstein MF, Folstein SE, McHugh PR (1975). ""Mini-mental state". A practical method for grading the cognitive state of patients for the clinician". *Journal of Psychiatric Research* **12** (3): 189–98.

Participant ID# ___________________

MINI-MENTAL STATE EXAMINATION (MMSE)
ANSWER SHEET

		Score	*Points*
Orientation			
1. What is the	Year?	_____	1
	Season?	_____	1
	Date?	_____	1
	Day?	_____	1
	Month?	_____	1
2. Where are we?	State?	_____	1
	County?	_____	1
	Town or city?	_____	1
	Hospital/other facility?	_____	1
	Floor?	_____	1
Registration			
3. Name three objects (bed, apple, shoe), taking one second to say each. Then ask the subject all three after you have said them. Give one point for each correct answer. Repeat the answers until the subject learns all three (give up to 6 trials).		_____	3
4. Serial sevens. Ask the subject to begin with 100 and count backwards by 7. Give one point for each correct answer. Stop after five answers (93, 86, 79, 72, 65). *Alternate:* Spell WORLD backwards. The score is the number of letters in correct order, e.g., dlrow=5, dlorw=3.		_____	5
Recall			
5. Ask for names of three objects learned in question 3. Give one point for each correct answer.		_____	3
Language			
6. Point to a pencil and a watch. Have the subject name them as you point.		_____	2
7. Have the subject repeat "No ifs, ands, or buts."		_____	1
8. Have the subject follow a three-stage command. "Take the paper in your right hand. Fold the paper in half. Put the paper on the floor."		_____	3
9. Have the subject read and obey the following: "CLOSE YOUR EYES." (Write it in large letters.)		_____	1
10. Have the subject write a sentence of his or her own choice. (The sentence should contain a subject and a verb and should make sense.) Ignore spelling errors when scoring.		_____	1
11. Have the subject copy the figure below. (Give two overlapping pentagons and one point if all sides and angles are preserved and if the intersecting sides form a quadrangle).		_____	1
		_____	Total = 30

Source: Copyright © Marshall Folstein, M.D.



Geriatric Depression Scale (GDS)[1]

Administration

The GDS can be either self-administered or administered via personal interview. This handbook contains forms for each type of administration. If using self-administration, be sure to use the form that does not have instructions for scoring. Each respondent should be queried concerning his/her understanding of the instructions, and probed regarding difficulty answering any specific items.

Instructions to Participants

"Choose the best answer ('yes' or 'no') for how you felt over the past week. If you have any questions about answering any of the items, please ask the administrator." For self-administration, the participant should circle the "yes" or "no" response for each item.

Instructions for Scoring

Count the number of responses circled in column A. A total greater than 12 may indicate depression.

The short form consists of 15 questions including items 1-4, 7-9, 12, 14, 15, 17, and 21-23. A total greater than 4 column A responses may indicate depression.

NOTE: *At McDowell Senior Center events, any participant who scores positive for depression (score of 6 or higher on GDS Short Form) should be asked whether he/she would like information about the Healthy IDEAS program, and/or would like to speak with the Senior Center Director (who has received Healthy IDEAS training).*

[1] Yesavage JA, Brink TL, Rose TL, et al. Development and validation of a geriatric depression screening scale: a preliminary report. J Psychiatr Res. 1983;17:37-49.

Participant ID#: ________________________ Date: _____________

GERIATRIC DEPRESSION SCALE[1]

Instructions: *Choose the best answer for how you felt over the past week.*
Note: *When asking the participant to complete the form, provide the self-rated form.*

	Question	A	B
1.	Are you basically satisfied with your life?	No	Yes
2.	Have you dropped many of your activities and interests?	Yes	No
3.	Do you feel that your life is empty?	Yes	No
4.	Do you often get bored?	Yes	No
5.	Are you hopeful about the future?	No	Yes
6.	Are you bothered by thoughts that you just can't get out of your head?	Yes	No
7.	Are you in good spirits most of the time?	No	Yes
8.	Are you afraid that something bad is going to happen to you?	Yes	No
9.	Do you feel happy most of the time?	No	Yes
10.	Do you often feel helpless?	Yes	No
11.	Do you often get restless and fidgety?	Yes	No
12.	Do you prefer to stay home at night, rather than go out and do new things?	Yes	No
13.	Do you frequently worry about the future?	Yes	No
14.	Do you feel that you have more problems with memory than most?	Yes	No
15.	Do you think that it is wonderful to be alive now?	No	Yes
16.	Do you often feel downhearted and blue?	Yes	No
17.	Do you feel pretty worthless the way you are now?	Yes	No
18.	Do you worry a lot about the past?	Yes	No
19.	Do you find life very exciting?	No	Yes
20.	Is it hard for you to get started on new projects?	Yes	No
21.	Do you feel full of energy?	No	Yes
22.	Do you feel that your situation is hopeless?	Yes	No
23.	Do you think most persons are better off than you are?	Yes	No
24.	Do you frequently get upset over little things?	Yes	No
25.	Do you frequently feel like crying?	Yes	No
26.	Do you have trouble concentrating?	Yes	No
27.	Do you enjoy getting up in the morning?	No	Yes
28.	Do you prefer to avoid social gatherings?	Yes	No
29.	Is it easy for you to make decisions?	No	Yes
30.	Is your mind as clear as it used to be?	No	Yes

Score: Count responses circled in column A. A total greater than 12 may indicate depression.

Short form consists of 15 questions including items 1-4, 7-9, 12, 14, 15, 17, and 21-23. A total greater than 4 column A responses may indicate depression.

[1] Yesavage JA, Brink TL, Rose TL, et al. Development and validation of a geriatric depression screening scale: a preliminary report. J Psychiatr Res. 1983;17:37-49.

Participant ID#: ________________________ Date: _____________

GERIATRIC DEPRESSION SCALE[1]

Instructions: *Choose the best answer for how you felt over the past week.*

		A	B
1.	Are you basically satisfied with your life?	No	Yes
2.	Have you dropped many of your activities and interests?	Yes	No
3.	Do you feel that your life is empty?	Yes	No
4.	Do you often get bored?	Yes	No
5.	Are you hopeful about the future?	No	Yes
6.	Are you bothered by thoughts that you just can't get out of your head?	Yes	No
7.	Are you in good spirits most of the time?	No	Yes
8.	Are you afraid that something bad is going to happen to you?	Yes	No
9.	Do you feel happy most of the time?	No	Yes
10.	Do you often feel helpless?	Yes	No
11.	Do you often get restless and fidgety?	Yes	No
12.	Do you prefer to stay home at night, rather than go out and do new things?	Yes	No
13.	Do you frequently worry about the future?	Yes	No
14.	Do you feel that you have more problems with memory than most?	Yes	No
15.	Do you think that it is wonderful to be alive now?	No	Yes
16.	Do you often feel downhearted and blue?	Yes	No
17.	Do you feel pretty worthless the way you are now?	Yes	No
18.	Do you worry a lot about the past?	Yes	No
19.	Do you find life very exciting?	No	Yes
20.	Is it hard for you to get started on new projects?	Yes	No
21.	Do you feel full of energy?	No	Yes
22.	Do you feel that your situation is hopeless?	Yes	No
23.	Do you think most persons are better off than you are?	Yes	No
24.	Do you frequently get upset over little things?	Yes	No
25.	Do you frequently feel like crying?	Yes	No
26.	Do you have trouble concentrating?	Yes	No
27.	Do you enjoy getting up in the morning?	No	Yes
28.	Do you prefer to avoid social gatherings?	Yes	No
29.	Is it easy for you to make decisions?	No	Yes
30.	Is your mind as clear as it used to be?	No	Yes

[1] Yesavage JA, Brink TL, Rose TL, et al. Development and validation of a geriatric depression screening scale: a preliminary report. J Psychiatr Res. 1983;17:37-49.

Participant ID#: ________________________ Date: _____________

GERIATRIC DEPRESSION SCALE[1]
SHORT FORM

Instructions: *Choose the best answer for how you felt over the past week.*
Note: *For administration by interview format.*

		A	B
1.	Are you basically satisfied with your life?	No	Yes
2.	Have you dropped many of your activities and interests?	Yes	No
3.	Do you feel that your life is empty?	Yes	No
4.	Do you often get bored?	Yes	No
5.	Are you in good spirits most of the time?	No	Yes
6.	Are you afraid that something bad is going to happen to you?	Yes	No
7.	Do you feel happy most of the time?	No	Yes
8.	Do you often feel helpless?	Yes	No
9.	Do you prefer to stay home at night, rather than go out and do new things?	Yes	No
10.	Do you feel that you have more problems with memory than most?	Yes	No
11.	Do you think that it is wonderful to be alive now?	No	Yes
12.	Do you feel pretty worthless the way you are now?	Yes	No
13.	Do you feel full of energy?	No	Yes
14.	Do you feel that your situation is hopeless?	Yes	No
15.	Do you think most persons are better off than you are?	Yes	No

Score: Count responses circled in column A. A total greater than 4 may indicate depression.

[1] Yesavage JA, Brink TL, Rose TL, et al. Development and validation of a geriatric depression screening scale: a preliminary report. J Psychiatr Res. 1983;17:37-49.

Rapid Assessment of Physical Activity (RAPA)†

Description

A 9-item, self-administered questionnaire regarding current levels of physical activity of adults older than 50 years. RAPA evaluates a wide range of physical activity levels, from sedentary to vigorous activity, as well as strength and flexibility training.

Instructions to Participants

"Choose the best answer ('yes' or 'no') for each statement. If you have any questions about answering any of the items, please ask the administrator." For self-administration, the participant should check the "yes" or "no" response for each item.

Instructions for Scoring

Each question has a 'Yes' or 'No' option. The total score of the first seven items is out of 7; participants choose which question corresponds to their activity level. Any score less than 6 is considered suboptimal. Strength training and flexibility are scored separately (strength training = 1, flexibility = 2, both = 3)

† Topolski, T. D., LoGerfo, J., Patrick, D. L., Williams, B., Walwick, J., Patrick, M. B. (2006). The Rapid Assessment of Physical Activity (RAPA) among older adults. *Preventing Chronic Disease, 3*(4), 1-8.

How Physically Active Are You?

An assessment of level and intensity of physical activity

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http://depts.washington.edu/hprc/rapa

Rapid Assessment of Physical Activity

Physical Activities are activities where you move and increase your heart rate above its resting rate, whether you do them for pleasure, work, or transportation.

The following questions ask about the amount and intensity of physical activity you usually do. The intensity of the activity is related to the amount of energy you use to do these activities.

Examples of physical activity intensity levels:

Intensity	Examples
Light activities • your heart beats slightly faster than normal • you can talk and sing	Walking Leisurely; Stretching; Vacuuming or Light Yard Work
Moderate activities • your heart beats faster than normal • you can talk but not sing	Fast Walking; Aerobics Class; Strength Training; Swimming Gently
Vigorous activities • your heart rate increases a lot • you can't talk or your talking is broken up by large breaths	Stair Machine; Jogging or Running; Tennis, Racquetball, Pickleball or Badminton

How physically active are you? *(Check one answer on each line)*

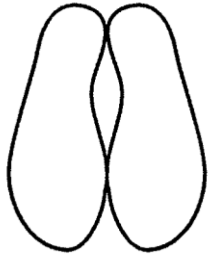
		Statement	Does this accurately describe you?
RAPA 1	1	I rarely or never do any physical activities.	Yes ☐ No ☐
	2	I do some **light** or **moderate** physical activities, but not every week.	Yes ☐ No ☐
	3	I do some **light** physical activity every week.	Yes ☐ No ☐
	4	I do **moderate** physical activities every week, but less than 30 minutes a day or 5 days a week.	Yes ☐ No ☐
	5	I do **vigorou**s physical activities every week, but less than 20 minutes a day or 3 days a week.	Yes ☐ No ☐
	6	I do 30 minutes or more a day of **moderate** physical activities, 5 or more days a week.	Yes ☐ No ☐
	7	I do 20 minutes or more a day of **vigorous** physical activities, 3 or more days a week.	Yes ☐ No ☐
RAPA 2 (3 = Both 1 & 2)	1	I do activities to increase muscle **strength**, such as lifting weights or calisthenics, once a week or more.	Yes ☐ No ☐
	2	I do activities to improve **flexibility**, such as stretching or yoga, once a week or more.	Yes ☐ No ☐

ID # ________________________________

Today's Date ________________________

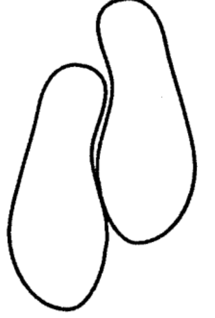
Stance Positions

FEET TOGETHER STAND



SEMI-TANDEM STAND

- The person chooses which foot is placed in front
- Hold for 10 seconds



TANDEM STAND

- The person chooses which foot is placed in front
- Hold for 10 seconds

ONE LEG STAND

- The person chooses which foot to stand on
- Timing starts as soon as the person raises one foot off the ground
- We chose to extend the maximum length of time of the one leg stand test from 10 seconds to 30 seconds to lessen the ceiling effects of this test

Four Stage Balance Test*

- Includes four timed static balance tasks of increasing difficulty that are completed without assistive devices (see figure opposite for position of feet).
- No practices are allowed before each task.
- The assessor can help the person to assume each foot position, then the person should indicate when ready to begin unaided.
- If the person cannot assume the position, do not continue (enter time of "0" seconds.
- Time feet together, semi-tandem and tandem positions for up to 10 seconds and one leg stand for up to 30 seconds.
- Timing is stopped if:
  - The person moves feet from the proper position.
  - The assessor provides support to prevent a fall.
  - The person touches the wall or external object for support.

*Campbell AJ, Robertson MC. Otago exercise programme to prevent falls in older adults. New Zealand: Otago Medical School, University of Otago; 2003.

Hand Grip Dynamometry*

- Have the participant sit comfortably.
- Shoulder is adducted and neutrally rotated, elbow is flexed to 90 degrees, forearm and wrist are in neutral.
- Rotate peak-hold needle counterclockwise to 0.
- Let the participant comfortably grip the instrument in his/her hand.
- Have participant squeeze with maximum strength, saying “Squeeze as hard as you can...harder!...harder!...relax.”
- Each test should be repeated 3 times for each hand.
- Use the average of the 3 successive trials as the recorded result.

*Gill D, Reddon J, Renney C, Stefanyk W. Hand dynamometer: Effects of trials and session. Perceptual and Motor Skills 1985; 61:195-198.

30-Second Chair Stand Test*

Testing outcome

The 30 second chair stand test provides a measurement of a person's lower body (particularly leg) strength. This is associated with the ability to perform lifestyle tasks such as climbing stairs, getting in and out of a vehicle or bath.

Equipment required

- A chair with a straight back and a seat at 43 cm.
- A stop watch.

Instructions for participant

1. Sit in the middle of the chair.
2. Place your hands on the opposite shoulder crossed at the wrists.
3. Keep your feet flat on the floor.
4. Keep your back straight.
5. On the signal to begin rise to a full stand position and then sit back down again.
6. Repeat this for 30 seconds.

Measurement

- On the signal to begin, start the stop watch.
- Count the number of times the client comes to full standing position in 30 seconds.
- If the client is over halfway to a standing position when 30 seconds have elapsed count it as a stand.
- Record the number of times the participant stands in 30 seconds.

Safety issues

- Make sure the chair cannot slide backwards by placing the rear legs against a wall.
- If a person cannot stand even once allow the hands to be placed on the legs or use a cane or walker. The score is zero but record the number of stands as an adapted test score. Indicate the adaptations made to the test.
- Have a person ready to catch the participant should they lose balance.
- Allow the participant to stop and rest if they become tired. The time keeps going.

*30-Second Chair Stand Test, National VET, accessed February 2, 2015, https://nationalvetcontent.edu.au/alfresco/d/d/workspace/SpacesStore/efcaa5b0-1c5b-40f7-bd55-64a59158f7cf/805/fit_tb/fit011_1_lr10/fit011_1_lr10_1_1.htm

Timed Up and Go Test (TUG)*

The timed "Up & Go" test measures, in seconds, the time taken by an individual to stand up from a standard arm chair (approximate seat height of 46 cm, arm height 65 cm), walk a distance of 3 meters (approximately 10 feet), turn, walk back to the chair, and sit down again.

The participant wears his/her regular footwear. If participant usually uses an assistive device such as a cane or walker, he/she **should** use the device during the test. The assistive device should be indicated on the assessment form. No physical assistance is given unless needed to prevent a fall.

Setting up the test area

- Determine a path free from obstruction.
- Place a chair with arms at one end of the path.
- Mark off a 3 m (10 ft.) distance using tape or a cone or other clear marking.

Start the test

- Speak clearly and slowly.
    - Inform participant of sequence and outcome
      "When I say go, you will stand up from the chair, walk past the mark on the floor, turn around, walk back to the chair and sit down." "I will be timing you using the stopwatch."
- Participant starts with back against the chair, arms resting on arm rests, and walking aid at hand.
- Use the cue "Ready, go".
- Do 1 practice and 2 timed tests.
- Use a stopwatch to time the performance.

*Podsiadlo D, Richardson S. The timed "Up & Go": a test of basic functional mobility for frail elderly persons. *J Am Geriatr Soc*. 1991;39:142-148.

FORMS: EXERCISE AND OTHER RECOMMENDATIONS

Weights issued (check) ☐ Date ______

EXERCISE PRESCRIPTION

NAME		Visit 1	Visit 2	Visit 3	Visit 4
DATE					
EXERCISE DESCRIPTION	#				
ROM EXERCISES - daily					
Head movements	34				
Neck movements	35				
Back extension	36				
Trunk movements	37				
Ankle movements	38				
STRENGTHENING EXERCISES - 3x/week					
Knee extension	40	Reps R Reps L lbs. weight	Reps R Reps L lbs. weight	Reps R Reps L lbs. weight	Reps R Reps L lbs. weight
Knee flexion	41	Reps R Reps L lbs. weight	Reps R Reps L lbs. weight	Reps R Reps L lbs. weight	Reps R Reps L lbs. weight
Hip abduction	42	Reps R Reps L lbs. weight	Reps R Reps L lbs. weight	Reps R Reps L lbs. weight	Reps R Reps L lbs. weight
Heel raises – UE support	43				
Heel raises – no UE support	44				
Toe raises – UE support	45				
Toe raises – no UE support	46				
BALANCE EXERCISES - daily					
Knee bends – UE support	48	Reps	Reps	Reps	Reps
Knee bends – no UE support	49	Reps	Reps	Reps	Reps
Backwards walking – UE support	50				
Backwards walking – no UE support	51				
Figure-8 walking	52				
Sideways walking	53				
Tandem stance – UE support	54				
Tandem stance – no UE support	55				
Tandem walking – UE support	56				
Tandem walking – no UE support	57				
One leg stand – UE support	58				
One leg stand – no UE support for 10 sec	59				
One leg stand – no UE support for 30 sec	60				
Heel walking – UE support	61				
Heel walking – no UE support	62				
Toe walking – UE support	63				
Toe walking – no UE support	64				
Tandem walking backward	65				
STS – both UEs	66	Reps	Reps	Reps	Reps
STS – 1 UE	67	Reps	Reps	Reps	Reps
STS – no UE	68	Reps	Reps	Reps	Reps
Stair walking	69	Steps	Steps	Steps	Steps

Participant Name___________________________________ Date _______________________

COMMUNITY HEALTH AND MOBILITY PARTNERSHIP (CHAMP)

Participant Recommendations

Risk Factor Category	General Suggestions (pay special attention to items marked with an "x" – indicates particular application to you)	Recommendation/ Action Plan
Balance Confidence ☐ OK ☐ Area of concern	☐ Try to have a good match between your level of confidence and your actual balance abilities. ☐ You may be overestimating your abilities. ☐ You may be underestimating your abilities.	☐ Talk to your doctor about physical therapy ☐ Consider joining a Matter of Balance or Tai Chi class if offered in your area
Medical Conditions ☐ OK ☐ Area of concern	Medical concerns: ______________________ ______________________ ______________________	☐ These specific concerns will be included in letter sent to your physician
Thinking or Mood ☐ OK ☐ Area of concern	☐ Try to avoid situations in which you have to do 2 or more things at once (such as walking while talking on the phone). ☐ Walk or perform other continuous exercise daily.	☐ Test scores will be included in letter sent to your physician. ☐ Talk with your doctor about possible depression.
Blood Pressure Sitting **BP** ____/_____ **Pulse** ______ **Postural hypotension** ☐ Yes ☐ No ☐ OK ☐ Area of concern	☐ Be sure to take your blood pressure medications as prescribed. ☐ Check your blood pressure regularly at home or at a local pharmacy. ☐ Don't attempt walking while dizzy. ☐ Get up slowly and wait for symptoms to resolve before moving further. Stand for a few moments before walking. ☐ Do ankle pumps, bend/straighten knees, or wiggle toes while waiting for symptoms to resolve. ☐ Drink adequate/recommended amount of fluids, particularly when febrile or experiencing gastrointestinal illnesses and in hot weather.	☐ Talk with your doctor about your blood pressure control. ☐ Have your heartbeat and blood pressure assessed by your doctor both lying down and standing. ☐ Have medications reviewed by your doctor for possible relationship to postural hypotension.

Adapted from: Hennepin County Community Health Department, Senior Fall Prevention Screening Kit, Minneapolis, MN. March 2002.

Participant Name___________________________ Date ___________________

Medication ☐ OK ☐ Area of concern	☐ Have your doctor review all of your medications, dosages, side effects, interactions, and why and how you should take them. ☐ Always take your medications as prescribed by your doctor. Never stop taking medications without talking to your doctor. ☐ Discuss the following high-risk medications with your doctor: ____________________ ____________________ ____________________	☐ Medication concerns will be included in letter sent to your physician. ☐ Contact the Department of Social Services to obtain assistance in purchasing medications
Vision ☐ OK ☐ Area of concern	☐ Use a magnifying glass or get assistance reading medication bottles. ☐ Use night lights when getting up at night. ☐ Keep your glasses within reach of bed at night. ☐ Clear clutter and cords from your home. ☐ Remember that it is sometimes difficult to judge distance. ☐ Do not walk while wearing reading glasses. ☐ Allow time for eyes to accommodate to changing levels of light.	☐ Have your eyesight checked by an eye doctor Other Action Items to help reduce risks related to decreased eyesight:
Balance ☐ OK ☐ Area of concern	☐ Talk to your doctor about need for a cane, walking stick, or other device. ☐ Use handrails on stairs. ☐ Consider installing grab bars in the bathroom and/or using a shower or tub chair. ☐ Use extra caution when stepping over obstacles.	☐ Do daily balance exercises. ☐ Talk to your doctor about physical therapy to improve your balance.
Footwear ☐ OK ☐ Area of concern	☐ Shoe style should be nonskid, well-fitting shoe with low heels and flat, wide soles. ☐ Shoes should have laces or Velcro closures. ☐ Shoes should be sturdy, with good arch support.	☐ Identify shoe stores in your area for best fitting/advice. ☐ You will be included in free footwear program.

Adapted from: Hennepin County Community Health Department, Senior Fall Prevention Screening Kit, Minneapolis, MN. March 2002.

Participant Name________________________________ Date ______________________

Strength ☐ OK ☐ Area of concern	☐ Use a squeeze ball, hand exerciser, or theraputty. ☐ Wring out wet washcloths or cleaning cloths to strengthen your hands. ☐ Play racquet sports. ☐ Take stairs instead of elevator or escalator. ☐ Garden or perform other activities that require you to get up and down frequently.	☐ Perform strengthening exercises 2-3 times a week. ☐ Participate in a community exercise class. ☐ Talk to your doctor about physical therapy to improve your strength.
Mobility ☐ OK ☐ Area of concern	☐ Maintain proper adjustment and/or use of cane or walker. ☐ Use proper standing, sitting or turning strategies to maximize safety ☐ Use extra caution on uneven surfaces (walk slower, use railings). ☐ Choose a parking place farther from your destination to increase your walking distance. ☐ Use a pedometer to count the number of steps you take per day, and try to increase	☐ Participate in one or more community physical activity programs. ☐ Talk to your doctor about physical therapy to improve your mobility. ☐ Replace rubber tips on canes and walkers if they are worn.
History of Falling ☐ OK ☐ Area of concern	☐ Review home safety hazards. ☐ Develop a plan for what you will do in the event of a fall. ☐ Review information about Lifeline.	☐ Do a home safety check with another individual. ☐ Complete recommended home modifications.

☐ Return to this site for follow-up visit(s) on: ________________________________

☐ Keep up the good work! No follow-up is indicated at this time. Schedule another visit if your condition changes, or if you have new concerns about your balance or mobility.

Adapted from: Hennepin County Community Health Department, Senior Fall Prevention Screening Kit, Minneapolis, MN. March 2002.

CHAMP The Community Health and Mobility Partnership

Date: __________________

Dr. ____________________________

We recently had the opportunity and pleasure of screening and assessing one of your patients (Name)__________________________, DOB: ____________________ for strength, balance, and mobility issues and risk of falling as part of the Community Health and Mobility Partnership (CHAMP) program.

We felt it was important to inform you of your patient's assessment results and recommendations per the CHAMP primary care provider assessment/recommendations form. We will keep you apprised of any additional concerns or significant changes in (Name) _____________________________ status during his/her participation in the CHAMP program.

For more details about CHAMP, please see: https://ncchamp.org/about

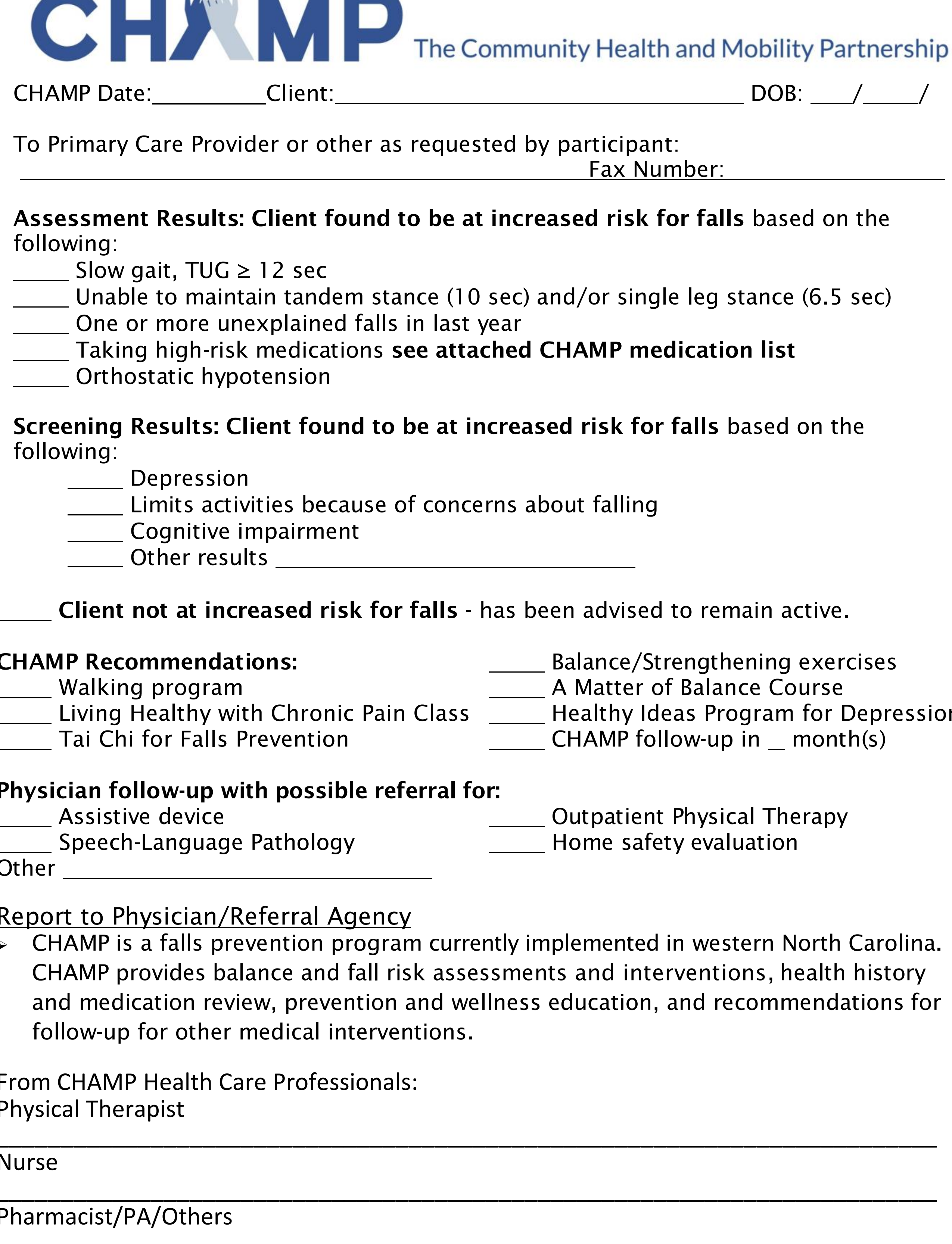
Thank you for the ongoing care of patients in our community. If you have any questions or concerns, please do not hesitate to reach out to us.

Thank you,

Jennie Rhyne, PT
Mobile: 704-742-0981

Martha Zimmerman, PT
Mobile: 828-443-1262

Vicki Mercer, PT, PhD
Work: 919-843-8642



CHAMP The Community Health and Mobility Partnership

CHAMP Date:__________Client:____________________________________ DOB: ____/_____/

To Primary Care Provider or other as requested by participant:
____ Fax Number:__________________

Assessment Results: Client found to be at increased risk for falls based on the following:

_____ Slow gait, TUG ≥ 12 sec
_____ Unable to maintain tandem stance (10 sec) and/or single leg stance (6.5 sec)
_____ One or more unexplained falls in last year
_____ Taking high-risk medications **see attached CHAMP medication list**
_____ Orthostatic hypotension

Screening Results: Client found to be at increased risk for falls based on the following:

_____ Depression
_____ Limits activities because of concerns about falling
_____ Cognitive impairment
_____ Other results ________________________________

_____ **Client not at increased risk for falls** - has been advised to remain active.

CHAMP Recommendations:

_____ Walking program
_____ Living Healthy with Chronic Pain Class
_____ Tai Chi for Falls Prevention
_____ Balance/Strengthening exercises
_____ A Matter of Balance Course
_____ Healthy Ideas Program for Depression
_____ CHAMP follow-up in _ month(s)

Physician follow-up with possible referral for:

_____ Assistive device
_____ Speech-Language Pathology
_____ Outpatient Physical Therapy
_____ Home safety evaluation
Other _________________________________

Report to Physician/Referral Agency

- CHAMP is a falls prevention program currently implemented in western North Carolina. CHAMP provides balance and fall risk assessments and interventions, health history and medication review, prevention and wellness education, and recommendations for follow-up for other medical interventions.

From CHAMP Health Care Professionals:
Physical Therapist
____
Nurse
____
Pharmacist/PA/Others
____

CHAMP contacts: (Buncombe County) Jennie Rhyne, PT, phone 704-742-0981, email jenniegrhyne@gmail.com
(McDowell County) Martha Zimmerman, PT, phone 828-443-1626; email mzimmerman0988@gmail.com
(UNC-Chapel Hill) Vicki Mercer, PT, PhD, phone 919-843-8642; email vmercer@med.unc.edu

REFERRAL FORM

Fall Prevention Patient Referral

PATIENT INFORMATION

Patient:	Referred to:
Sex: ☐ Male ☐ Female DOB: / /	
Address:	Address:
Phone:	Phone:
Email:	Email:

Diagnosis:

TYPE OF REFERRAL

Type of specialist:

Exercise or fall prevention program:

Additional recommendations:

REASON FOR REFERRAL

☐ Gait or mobility problems	☐ Medication review & consultation
☐ Balance difficulties	☐ Inadequate or improper footwear
☐ Lower body weakness	☐ Foot abnormalities
☐ Postural hypotension	☐ Vision <20/40 in ☐ Right ☐ Left ☐ Both
☐ Suspected neurological condition (e.g., Parkinson's disease, dementia)	☐ Home safety evaluation led by occupational therapist

Other reason:

Other relevant information:

Referrer signature: Date:

Centers for Disease Control and Prevention
National Center for Injury Prevention and Control

2017

FORMS: ADMINISTRATIVE

COMMUNITY HEALTH AND MOBILITY PARTNERSHIP (CHAMP)

Checklist for First-Time Volunteers

INFORMATION ABOUT THE VOLUNTEER

Name: Credentials (e.g., RN, ATC, PT): License no.

Discipline: E-mail address:

Student? ☐ Yes ☐ No
If yes, what school do you attend?
How many years have you been in this degree/certificate program? This is my year.

Instructions to faculty completing this form for student volunteers: Please check off all competencies that apply to this student, and ***send the completed form by e-mail to the individual who will be supervising the student at CHAMP. The supervisor should receive the completed form at least one day before the event****.*

KNOWLEDGE CHECKLIST

☐ Oriented to CHAMP policies and procedures (see Policies and Procedures Manual)

☐ Oriented to Otago Exercise Programme (see Otago Exercise Programme Manual)

☐ Completed coursework in therapeutic exercise

☐ Completed online Otago training for PTs, available through AHEConnect

☐ Completed Free Your Feet training for assessing participants for appropriate footwear

SKILLS CHECKLIST

INTAKE

☐ Obtaining participant consent and assisting participants with Participant Information Form

☐ Administering and scoring Activities-specific Balance Confidence (ABC) Scale

☐ Administering and scoring Geriatric Depression Scale (GDS)

☐ Administering and scoring the Rapid Assessment of Physical Activity (RAPA) scale

HEALTH ASSESSMENT PROCEDURES

☐ Measuring body weight

☐ Reviewing medical history

☐ Measuring blood pressure in supine, sitting, and standing

☐ Screening vision (indicate whether basic screen only ☐ or with use of special equipment ☐)

☐ Administering and scoring Mini-Mental State Exam

☐ Performing medication review, including identification of high-risk medications

PHYSICAL PERFORMANCE TESTING PROCEDURES

- ☐ Administering Four Test Balance Scale
- ☐ Measuring grip strength
- ☐ Administering Timed Chair Stands test
- ☐ Administering Timed Up & Go (TUG) test

PROCEDURES FOR INTERVENTION RECOMMENDATIONS AND EXERCISE INSTRUCTION

- ☐ Interpreting test results to identify risk of falls
- ☐ Making exercise recommendations (selecting appropriate Otago exercises)
- ☐ Instructing participant in performance of Otago exercises (a check in the box for this item reflects knowledge of correct performance of every exercise included in the Otago Exercise Programme)
- ☐ Reviewing home exercise performance with participants at follow-up appointments
- ☐ Making revisions to home exercise program at follow-up
- ☐ Determining participant readiness for “graduation” from CHAMP

If completing this form **for yourself** as a faculty member or clinician volunteering for CHAMP for the first time:

I attest that I have completed this checklist to accurately reflect my knowledge and skills for providing services at CHAMP events.

NAME: **DATE:**

If completing this form **for your student** as the student’s faculty member:

I attest that I have completed this checklist to accurately reflect this student’s knowledge and skills for providing services at CHAMP events.

NAME: **DATE:**

CHAMP

COMMUNITY HEALTH AND MOBILITY PARTNERSHIP

Sign Up for: Screening Event
Date

Time	RETURNING CHAMP PARTICIPANTS	"NEW" CHAMP PARTICIPANTS
8:30 AM	Name: Phone:	Name: Phone:
9:00 AM	Name: Phone:	Name: Phone:
9:30 AM	Name: Phone:	Name: Phone:
10:00 AM	Name: Phone:	Name: Phone:
10:30 AM	Name: Phone:	Name: Phone:
11:00 AM	Name: Phone:	Name: Phone:
11:30 AM	Name: Phone:	NO NEW PARTICIPANTS FROM 11:30PM-1:00PM
1:00 PM	Name: Phone:	Name: Phone:
1:30 PM	Name: Phone:	Name: Phone:
2:00 PM	Name: Phone:	Name: Phone:
2:30 PM	Name: Phone:	NO NEW PARTICIPANTS AFTER 2:30PM

CHAMP The Community Health and Mobility Partnership

SCRIPT FOR APPOINTMENT REMINDER PHONE CALLS

Hello Mr./Ms.________________,

My name is ______________ and I am calling on behalf of the CHAMP program to remind you about your scheduled appointment on Friday, (date of visit) at (time of visit). Your appointment will be at (location of visit).

If first visit→At your visit, a team of healthcare providers will assess your general health and your strength, balance, and mobility. Please wear comfortable clothing and walking or athletic shoes. Also, please remember to bring all of your current medications or a complete list of your current medications with you to the appointment.

If second or later visit→Please remember to bring your falls and exercise calendar with you to the appointment. A healthcare provider will review this calendar with you at the visit.

Do you have any questions about the appointment?

We’re looking forward to seeing you soon. Thank you, and I hope you have a great day!

SCRIPT FOR FOLLOW-UP PHONE CALLS

Hello Mr./Ms.________________,

My name is ______________ and I am calling on behalf of the CHAMP program to follow up with you about your visit on Friday, (date of visit) at (location of visit). How are you doing today? Do you have a few minutes to answer some quick questions?

No→ Ok, no problem. Is there a time I could try calling back that would work better for you?

Yes→ Great, I first want to check in with you about the exercises you were given at the end of your visit. Have you been performing the exercises at home?

> **Yes →** That's great! Have any of the exercises been giving you trouble or do you have any questions about the pictures you were given?
>
> Have you been filling out the calendar in your folder to help you stay on track with your exercises, and also to record any falls you've had? (Follow up with the participant and record details if he/she reports having had a fall since the CHAMP evaluation.)
>
> > Yes→ Excellent! It sounds like you are doing very well! Keep up the good work!
> > No→ You may find the calendar to be a useful tool to keep track of your progress. Remember that the calendar has a place to indicate whether you have done your exercises each day, and also a place to mark either "yes" if you had a fall or "no" if you did not have a fall that day.
>
> **No →** That's ok, today is a good day to start. I'd like to help you begin to incorporate the exercises into your daily routine. These exercises are important to help strengthen your muscles and lessen your risk of a fall. Are you having trouble performing the exercises or do you have any questions about the pictures you were given?
>
> If it has been difficult for you to remember to do the exercises, filling out the exercise and falls calendar in your folder is a good way to help you stay on track.

I appreciate you speaking with me today. We're looking forward to seeing you at your next CHAMP visit on (date of next visit). Please remember to bring your red folder (with falls/exercise calendar) with you when you come. Thank you for your time and I hope you have a great day!

**If the participant reports any significant issues or pain with exercises, arrange for follow-up call from Vicki (vmercer@med.unc.edu)*

COMMUNITY HEALTH AND MOBILITY PARTNERSHIP (CHAMP)

Confidentiality Agreement

Screening site: ____________________________ Screening Date: ______________________

I understand that the individuals who participate in this fall risk screening event must be assured that the personal and confidential information they provide on various forms and at the assessment stations will be protected from disclosure to anyone not authorized by the participant. Specifically, papers that contain personal identifying information (for example, name, address, telephone number, and medications on the registration form) and confidential information (for example, results and recommendations from the various assessments) must be kept in a locked place. Access must be limited to persons who will use the information only at the screening event or for follow up. The records should be destroyed at the participant's request or when the participant has not been involved with CHAMP for a period of 3 years or more. Copies of these records may be given to a participant's personal physician if such physician's name and address is included on a participant's signed consent form. I further understand that oral information gathered from participants during the screening is equally confidential and may not be divulged.

I agree not to divulge the information I see or hear at this screening event to anyone not specifically authorized by the participant. By signing and dating my signature below, I agree that I have read this document and understand it.

COMMUNITY HEALTH AND MOBILITY PARTNERSHIP (CHAMP)

Evaluation of Student Performance

Student Name: ____________________________ Evaluator: ______________________________

Student Discipline/ Degree Program: ______________________________ Date: ___________

Event Location: _________________________

Criteria	Excellent (5 points)	Good (4 points)	Fair (3 points)	Poor (1 point)
Event preparation and set-up _____ **points**	Participates in all aspects. Shares thoughts & ideas. Assists with set-up & facilitates event logistics as able, consistent with prior arrangements.	Participates in most aspects, but does not problem-solve event logistics. Completes tasks as requested.	Participates at a minimal level in event set-up.	Does not participate in set-up (e.g., arrives late without making prior arrangements).
Interpersonal skills/ communication _____ **points**	Demonstrates high degree of interaction with all members of interdisciplinary team. Communicates clearly & appropriately with clients.	Demonstrates moderate degree of interaction with other team members. Interacts with others only when approached. Communicates appropriately with clients.	Demonstrates minimal degree of interaction with other team members. Shows limited communication with clients, & does not alter strategy when needed.	Shows unacceptable level of interaction.
Problem-solving _____ **points**	Prioritizes client problems and considers possible solutions. Uses available resources to solve problems. Recognizes need for referral and seeks out additional resources as needed.	Identifies client problems and possible solutions. Seeks assistance and resources as needed.	Identifies some client problems. Seeks assistance to find resources and solutions.	Fails to identify significant client problems or seek appropriate solutions.
Responsibility/ event participation _____ **points**	Participates actively & energetically, & shares ideas. Helps with all activities with a positive attitude. Demonstrates high level of preparation for specific activities.	Participates in all activities with a positive attitude. Demonstrates acceptable level of preparation for specific activities.	Participates at a minimal level in activities, or is not adequately prepared. Arrives late and/or leaves early.	Shows unacceptable level of participation. Only partially completes tasks, or does so grudgingly or with a poor attitude.
Professionalism _____ **points**	Projects professional image. Shares evidence-based information or clinical experiences. Places high value on well-being and dignity of clients.	Projects professional image. Shares from personal experiences. Treats clients with respect, and is sensitive to cultural differences.	Acceptable appearance. Demonstrates acceptable level of respect and sensitivity to cultural differences.	Shows unacceptable level of professionalism.
Use of constructive feedback _____ **points**	Demonstrates excellent self-awareness, and critiques own performance accurately. Seeks feedback from others. Responds effectively to constructive feedback.	Demonstrates good self-awareness. Accepts feedback from others with positive attitude, and takes action to address areas of weakness.	Demonstrates adequate self-awareness. Accepts feedback from others with positive attitude, but does not take action.	Shows poor self-awareness and/or responds negatively to feedback.

TOTAL = ______/30 points (____ %)

Comments:

Student Volunteer Survey

Thank you for your input! Please complete the following survey and turn in a hard copy or email your responses to your faculty representative at CHAMP.

What school do you attend? **What degree program are you in?**

What year are you in the program? ☐ 1st ☐ 2nd ☐ 3rd ☐ 4th +

1. **What facility did you visit for CHAMP? (Check all that apply.)**
   - ☐ Grove Street Senior Opportunity Center
   - ☐ McDowell Senior Center
   - ☐ Quest4Life (Caldwell County)
   - ☐ Other (please enter): ____
2. **How prepared did you feel coming in to CHAMP?**
   - ☐ Extremely Prepared
   - ☐ Very Prepared
   - ☐ Somewhat Prepared
   - ☐ Not Very Prepared
   - ☐ Not Prepared At All
3. **How would you rate your overall performance at CHAMP?**
   - ☐ Excellent
   - ☐ Very Good
   - ☐ Good
   - ☐ Fair
   - ☐ Poor
4. **Please rate your level of agreement with the following statement: "The faculty and/or health care professionals present at the event were helpful to me".**
   - ☐ Strongly Agree
   - ☐ Agree
   - ☐ Neutral
   - ☐ Disagree
   - ☐ Strongly Disagree
5. **Please rate your level of agreement with the following statement: "Participation in CHAMP helped me to better understand material from my courses".**
   - ☐ Strongly Agree
   - ☐ Agree
   - ☐ Neutral
   - ☐ Disagree
   - ☐ Strongly Disagree

6. **Please rate your level of agreement with the following statement: "Participation in CHAMP made me more aware of the roles of professionals in disciplines other than my own".**
   - ☐ Strongly Agree
   - ☐ Agree
   - ☐ Neutral
   - ☐ Disagree
   - ☐ Strongly Disagree
7. **Please rate your level of agreement with the following statement: "Participation in CHAMP helped prepare me to function as a member of an interprofessional health care team".**
   - ☐ Strongly Agree
   - ☐ Agree
   - ☐ Neutral
   - ☐ Disagree
   - ☐ Strongly Disagree
8. **How would you rate your overall experience at CHAMP?**
   - ☐ Excellent
   - ☐ Very Good
   - ☐ Good
   - ☐ Fair
   - ☐ Poor

9. **Is there any information that you wish you had been available to you prior to or during the CHAMP event?**

10. **Is there anything that you think should be changed about the CHAMP program?**

Additional comments:

COMMUNITY HEALTH AND MOBILITY PARTNERSHIP (CHAMP)

SURVEY

We are seeking feedback about the CHAMP program, which includes screening of blood pressure, muscle strength, balance, and mobility, along with recommendations for exercise.

Have you ever participated in a CHAMP screening event? (please check the appropriate box) ☐ YES ☐ NO

If you answered "yes" to this question, we would appreciate your feedback! Your responses will help us determine how well the program has been working and how it can be improved. Your responses will be anonymous, so please do not write your name anywhere on the survey. Thank you very much for your feedback!

To complete the survey:

- **Be sure to read all the answer choices before marking your answer.**
- **Answer each question by putting a legible check mark or "X" in the box to the left of your answer, like this:**

  ☑ OR ☒

- **Please answer every question, and please check only ONE answer per question.**

1. **How would you rate the CHAMP program overall?**
   - ☐ **Excellent**
   - ☐ **Very Good**
   - ☐ **Good**
   - ☐ **Fair**
   - ☐ **Poor**

2. **How satisfied are you with your experience as a participant in the CHAMP program?**
   - ☐ **Completely Satisfied**
   - ☐ **Mostly satisfied**
   - ☐ **Somewhat satisfied**
   - ☐ **A little satisfied**
   - ☐ **Not at all satisfied**

PLEASE TURN TO THE BACK OF THIS PAGE TO CONTINUE THE SURVEY

3. **How well did the health care providers at CHAMP work together to assess and make recommendations for you?**
   - ☐ **Extremely well**
   - ☐ **Very well**
   - ☐ **Somewhat well**
   - ☐ **Not so well**
   - ☐ **Not well at all**

4. **How do you feel about having health care students (physical therapy and nursing students) involved with the CHAMP program?**
   - ☐ **Strongly positive**
   - ☐ **Positive**
   - ☐ **Neutral**
   - ☐ **Negative**
   - ☐ **Strongly negative**

5. **Please rate your level of agreement with the following statement: "I have benefitted physically (for example, with better strength, balance, walking, or overall health) from my participation in CHAMP".**
   - ☐ **Strongly agree**
   - ☐ **Agree**
   - ☐ **Neutral**
   - ☐ **Disagree**
   - ☐ **Strongly disagree**

6. **What were the two BEST things about your CHAMP experience?**

7. **What were two things about your CHAMP experience that could have been better?**

Any additional comments or suggestions for improvement?

FORMS: FOOTWEAR

CHAMP Shoe Request Form: (please complete to obtain shoe appointment)

Do you have Diabetes? Yes or No (circle) **Participants who have diabetes cannot receive shoes from the CHAMP footwear program. If you answered yes, you should see your doctor for a referral to an appropriate foot specialist for diabetic footwear.**

Have you fallen in the past year? Yes or No (circle**) If yes, participants must have been seen in CHAMP before being seen in the footwear program. If yes, have you been seen in CHAMP?** Yes or No (circle) **Date Seen in CHAMP**: ______________

Name: ____

Address: ____

City, State: ____, ____________

Phone: (______)_______-_______________**Age**: ___________________ **Gender**: Male or Female (circle)

Shoe Size: _____ **Shoe Width**: _____ **Men's** or **Women's** (If 2 different shoe sizes: R_____/ L _____)

Medical or physical issues to consider in shoe selection:

____

____

____

Preferred Shoe Style: (Circle) Athletic Loafers Mary Janes Lace-ups Slip-ons Orthopedic shoes Velcro closure Open toe Open heel

Other: ____

Do you need? (circle) Wide toes Wide heels Narrow heels Narrow toe

Do you use shoe inserts or braces? Yes or No (circle) If yes, what are the shoe inserts or braces for?

____

What shoe brand and/or style have you worn recently that you find to be the best for you?

____

Below to be filled out by CHAMP volunteer____

Special Considerations: ____

Physical Therapist Signature: ____Date: __________

Footwear Program

Informed Consent and Liability Waiver

By initialing and signing below you acknowledge and agree to the following:
Disclaimer:
There are certain inherent risks associated with footwear that could cause discomfort, pain or injury. You have the right to stop or refuse the shoe fitting, especially if you feel any discomfort or pain at any time. The person fitting your shoes will take every precaution to ensure that you are protected from any potential hazards while you are being fitted for shoes. You should never be forced to perform any procedure that you do not wish to perform.

Consent:
I hereby agree to participate fully in the shoe fitting and to answer any and all questions regarding my medical history and current level of function and/or mobility fully and truthfully to the best of my ability.

I hereby acknowledge that I have been informed of inherent risks of participating in footwear program.
***I verify these statements by placing my initials here:__________**

RELEASE AND WAIVER OF LIABILITY AGREEMENT: *Footwear Program*
I ("Participant"____) attest that I understand the inherent risks and rewards of this footwear program. I hereby release CHAMP and *Free Your Feet* as well as any and all physical therapists, physical therapist assistants, volunteers and any and all persons, and managers and owners of property associated with the distribution of footwear, from any and all liability related to said risks. I am fully aware that I am participating at my own risk and will not hold those entities or persons named above responsible in the event of my incurring an injury or exacerbating any previously existing conditions I may have had. If I have any medical conditions, I have consulted with my physician to make sure that the CHAMP footwear program is appropriate for me to participate in.

I UNDERSTAND THAT IF AT ANY TIME I HAVE INCREASED PAIN, PRESSURE, NUMBNESS OR FEELING OF UNSTEADINESS RELATED TO THE SHOES I HAVE BEEN GIVEN, I WILL NO LONGER USE THE GIVEN SHOES AND SEEK MEDICAL ATTENTION. I AM VOLUNTARILY PARTICIPATING IN THIS COMMUNITY SERVICE WITH KNOWLEDGE OF THE RISK INVOLVED, AND I AGREE TO ASSUME RESPONSIBILITY FOR MY SAFTEY AND HEALTH ONCE I HAVE ACCEPTED THE FOOTWEAR.
***I verify this statement by placing my initials here:__________**

I UNDERSTAND THAT THERE ARE INCREASED RISKS OF INDIVIDUALS WITH A DIABETES DIAGNOSES. I HEREBY ATTEST THAT I HAVE NEVER BEEN TOLD THAT I HAVE DIABETES MELLITUS AND TO MY KNOWLEDGE I DO NOT CURRENTLY HAVE DIABETES MELLITUS TYPE 1 OR 2. IF I SHOULD BECOME AWARE THAT I DO IN FACT HAVE DIABETES MELLITUS TYPE 2 WITHIN THE NEXT 6 MONTHS OF THIS DATE, I WILL STOP USING THE SHOES I WAS GIVEN AND SEEK A REFERRAL FROM MY PRIMARY CARE PROVIDER FOR AN APPROPRIATE DIABETIC FOOTWEAR ASSESSMENT.
***I verify this statement by placing my initials here:__________**

I HAVE CAREFULLY READ THIS AGREEMENT AND FULLY UNDERSTAND ITS CONTENTS. I AM AWARE THAT THIS IS A RELEASE OF LIABILITY AND A CONTRACT BETWEEN MYSELF AND THE CHAMP PROGRAM AND SIGN IT OF MY OWN FREE WILL.

PARTICIPANT/RELEASOR:____ DATE:__________
Witness Signature: ____ DATE: __________

Footwear Program

Name:_______________________________________**Date:**_______________**Location:**_________________

SUBJECTIVE: **See Shoe Form completed by the participant**

OBJECTIVE: **Brannock : L** Toe______Arch_____Width____ **R** Toe______MTP_____Width_____

Gait: Antalgic ____ Trendelenburg R L **Decreased stance time**: R L **Short step length**: Y / N

POSTURAL OBSERVATION:

(Front) IC Height: Higher R___L___ASIS: Higher R___L__Grt Troch: Higher R___L___

LLD: Y N **Shorter** R___L___**Knee:** Varus / Valgus Notes:_______________________________________

Arch: **Pes Cavus:** (Scale 0-5) R__ L __ **Pes Planus:** R__ L __ **Hallux Valgus: R__ L ___**

Mortons Toe: Y / N **Box Toe:** Y / N **Double Diamonds:** Y / N **IP Joint Position:** Subluxed Y / N

Rearfoot Varus/Valgus: Y / N **Intoe or Outtoe Haglunds:**

Hammer Toes: R L **Other Abnormalities**: ____

***CALLUS FORMATION ON PLANTAR ASPECT*:**

R: Sole ___ Heel: Medial Lateral Middle MT: 1 2 3 4 5 Notes____________________________

L: Sole ____Heel: Medial Lateral Middle MT: 1 2 3 4 5 Notes____________________________

***PALPATION OF FOOT*:** Rigid Flexible S/S Hypermobility: Y / N

Notes:____

Pain: Y / N **Location:**____

WORN SHOE EVALUATION: **Type:** Athletic Dress **Sole**: Slick Grippy **Heel rise**: Y / N **Rocker**: Front Rear **Other:** Tight Loose_ **Where:** Laces Heel Toe _________ **Heel slip:** Y / N ___________________

Location of Wear Points: MT: Min Mod Severe **Heel**: Medial Lateral **Midsole Wear:** Min Mod Severe

Notes:____

Shoe Fitting:

Shoe Size	Brand	Model	Features	Fit

Patient Report after 10 minutes of walking:

Comfort:______________ **Stability:**______________ **Ease of Mobility:**___________________

Notes:____

Other Concerns: Y N **Where:**____

____