American Medical Response
Contra Costa County
Golden Age Life Improvement Program (GALIP)

- Fall Prevention Toolkit
- Meal Locator Tool
- Home Assessment Request
- Balance Test
- Fall Risk Checklist/Assessment
- F.A.S.T. Stroke Identification and Treatment
- AMR Vial of Life

Fall Prevention Toolkit:

Meals on Wheels - Diablo Region - Contra Costa County
Meal Locator: https://www.mealsonwheelsamerica.org/find-meals
Fall Prevention: https://www.mowdiabloregion.org/fall-prevention
Request and Assessment: https://www.mowdiabloregion.org/home-safety-modification-form

Meal Assistance or Volunteer information:
Meals on Wheels of Contra Costa
P.O. Box 3195
Martinez CA 94553
(866) 669-6697

FALLS ARE COMMON

- Falls are the leading cause of fatal and non-fatal injuries for older Americans. 1 in 4 older adults falls each year.
- Every 11 seconds, an older adult is treated in the emergency room for a fall.
- Every 19 minutes, an older adult dies from a fall.

FALLS CAN CAUSE SERIOUS INJURIES

- Falls result in injuries, such as hip fractures, broken bones, and head injuries. In fact, more than 2.8 million older adults are treated in emergency departments annually because of a fall, resulting in over 800,000 hospitalizations.

FALLS ARE COSTLY

- The average hospital cost for a fall injury is over $30,000. Falls, with or without injury, carry a heavy burden on quality of life. After a fall, many older adults develop a fear of falling and, as a result, limit their activities and social engagements. Fear of falling can result in further physical decline, depression, social isolation, and feelings of helplessness.

FALLS IMPACT CAREGIVERS, TOO

- Research has shown that after a care recipient's first fall, caregivers report a significant increase in caregiver burden, fear of falling, and depression.

Four Stage Balance Test

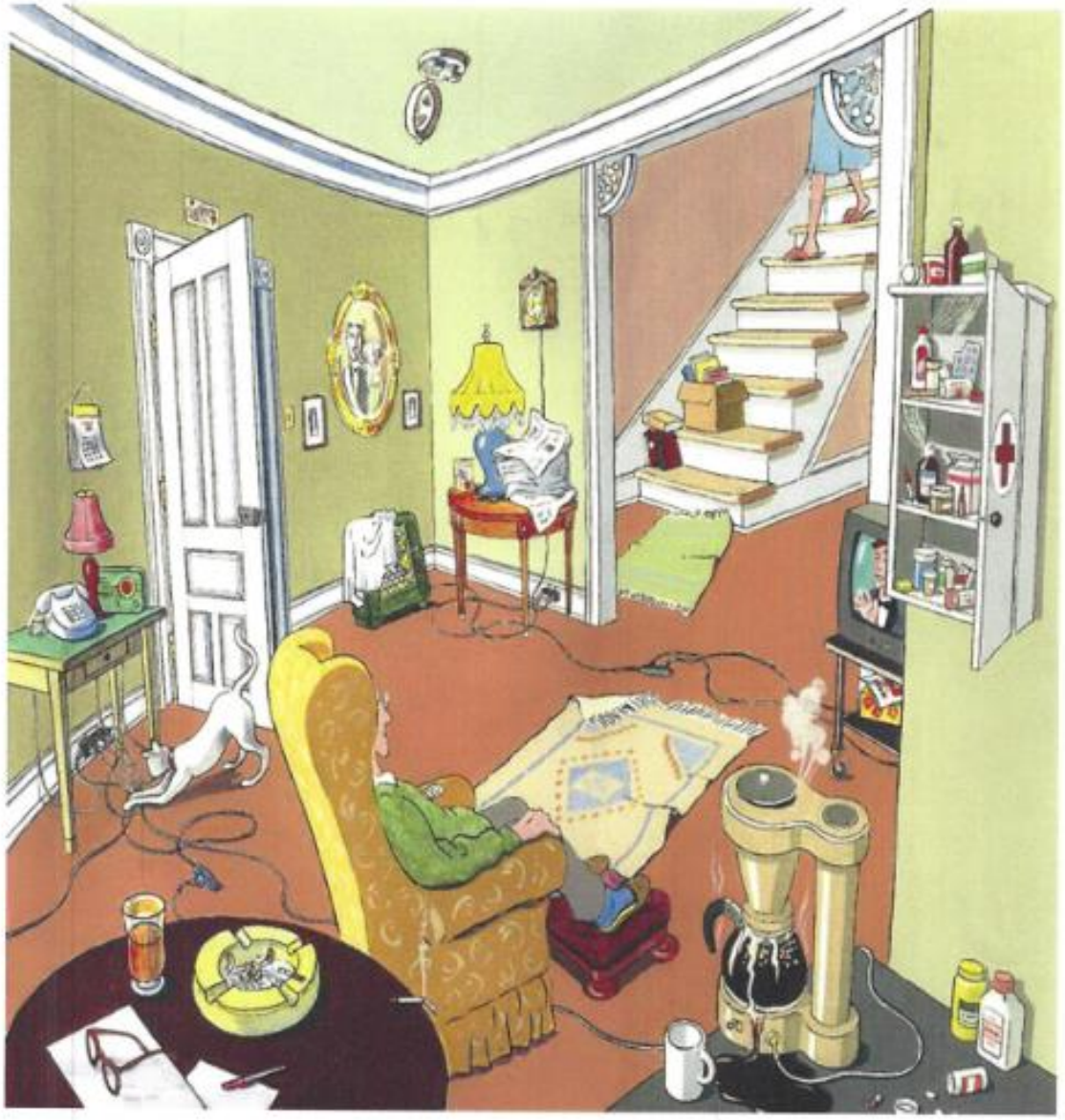
The purpose of this test is to assess static balance. The equipment needed is a stopwatch. This test includes four progressively more challenging positions. Participants should not use an assistive device (cane or walker) and should keep their eyes open and be in bare feet.

Describe and demonstrate each position. Stand next to the patient, hold their arm, and help them assume the correct foot position. When they are steady, let go, but remain ready to catch them if they should lose balance. If the patient can hold a position for 10 seconds without moving their feet or needing support, go on to the next position. If not, stop the test. An older adult who cannot hold tandem stance for at least 10 seconds is at an increased risk of falling.

Four- Stage Balance Test Instructions	
Participant	Physical Therapist
1. Stand in each position for 10 seconds. 2. You can hold your arms out or move your body to help keep your balance but do not move your feet. 3. Hold this position until you are told to stop.	1. For each stage, say "Ready, begin" and begin timing. 2. After 10 seconds, say "Stop."

Four- Stage Balance Test Stances			
Feet Together Stand	Semi-Tandem Stand	Tandem Stand	One Leg Stand
Stand with your feet side by side. 	Place the instep of one foot so it is touching the big toe of the other foot. 	Place one foot in front of the other, heel touching toe. 	Stand on one foot. 

This test is not meant to diagnose, treat, or prevent a fall. Please consult with your primary doctor.



WHAT'S WRONG WITH THIS PICTURE??

Check Your Risk for Falling

This checklist was developed by the Greater Los Angeles VA Geriatric Research Education Clinical Center and affiliates and is a validated fall risk self-assessment tool (Rubenstein et al. *J Safety Res*; 2011:42(6)493-499). Adapted with permission of the authors.

Select "Yes" or "No"		Statement:	Why it matters:
Yes (2)	No (0)	I have fallen in the past year.	People who have fallen once are likely to fall again.
Yes (2)	No (0)	I use or have been advised to use a cane or walker to get around safely.	People who have been advised to use a cane or walker may already be more likely to fall.
Yes (1)	No (0)	Sometimes I feel unsteady when I am walking.	Unsteadiness or needing support while walking are signs of poor balance.
Yes (1)	No (0)	I steady myself by holding onto furniture when walking at home.	This is also a sign of poor balance.
Yes (1)	No (0)	I am worried about falling.	People who are worried about falling are more likely to fall.
Yes (1)	No (0)	I need to push with my hands to stand up from a chair.	This is a sign of weak leg muscles, a major reason for falling.
Yes (1)	No (0)	I have some trouble stepping up onto a curb.	This is also a sign of weak leg muscles
Yes (1)	No (0)	I often have to rush to the toilet.	Rushing to the bathroom, especially at night, increases your chance of falling.
Yes (1)	No (0)	I have lost some feeling in my feet.	Numbness in your feet can cause stumbles and lead to falls.
Yes (1)	No (0)	I take medicine that sometimes makes me feel light-headed or more tired than usual.	Side effects from medicines can sometimes increase your chance of falling.
Yes (1)	No (0)	I take medicine to help me sleep or improve my mood.	These medicines can sometimes increase your chance of falling.
Yes (1)	No (0)	I often feel sad or depressed.	Symptoms of depression, such as not feeling well or feeling slowed down, are linked to falls.
Total____		Add up the number of points for each "yes" answer. If you scored 4 points or more, you may be at risk for falling. Discuss this brochure with your doctor.	

This tool is to help in identifying individuals who may be at greater risk of falling. It is not meant to diagnose, treat, or prevent a fall.

Please be sure to consult with your primary doctor to answer any questions and for tips on how to lessen the risk for falling.

F.A.S.T. *Stroke Identification and Treatment:*

Video Link Here: https://www.youtube.com/watch?v=Dg-eZRGscsw

Information and materials here: https://www.stroke.org/en/help-and-support/resource-library/fast-materials

Act FAST

Learn the many warning signs of a stroke. Act **FAST** and **CALL 9-1-1 IMMEDIATELY** at any sign of a stroke.

Use **FAST** to remember the warning signs:

F — **FACE:** Ask the person to smile. Does one side of the face droop?

A — **ARMS:** Ask the person to raise both arms. Does one arm drift downward?

S — **SPEECH:** Ask the person to repeat a simple phrase. Is their speech slurred or strange?

T — **TIME:** If you observe any of these signs, call 9-1-1 immediately.

It is important to recognize stroke symptoms and act quickly by **CALLING 9-1-1**.

Stroke Warning Signs

Stroke symptoms can also include:

SUDDEN numbness or weakness of face, arm or leg, especially on one side of the body

SUDDEN confusion, trouble speaking, or understanding

SUDDEN trouble seeing in one or both eyes

SUDDEN trouble walking, dizziness, loss of balance or coordination

SUDDEN severe headache with no known cause

Questions to Ask After a Stroke

- What caused my stroke?
- What type of stroke did I have?
- Where in the brain did the stroke occur?
- How soon can I expect to recover after my stroke?
- Will I need treatment and how will I know it is working?
- What are my treatment options?
- How effective is the treatment?
- What types of challenges are typical after this type of stroke?
- Will I have limitations because of the stroke?
- Will I be able to enjoy the same quality of life I had before the stroke?

Will I need to make changes to my lifestyle, like changing my eating or exercise habits?

Are there foods I need to avoid?

What level of exercise is safe for me to continue in order to prevent another stroke?

How can I lower my risk for having another stroke? What are the odds of me having another stroke?

What health conditions or risk factors do I have that place me at a higher risk for another stroke?

What are some additional tests I may need?

What is my prognosis?

Who can I turn to for support?

What follow-up is necessary?

Vial of Life:

Full PDF Link Download https://1317e8af-62ac-913d-828d-14d9efe3d727.filesusr.com/ugd/e78ebc_c9795f675e804fb895c67cc36595ca6c.pdf

All information shared with healthcare providers will be kept confidential and shall comply with HIPAA regulations.

Date of Birth: _____

Social Security Number: _____

Medical Insurance Provider: _____

Policy Number: _____

Group Number: _____

Secondary Insurance: _____

Policy Number: _____

Group Number: _____

Vial of Life

Your Health Information for 911 Providers

Critical Health and Contact Information for:

_____

First Name Middle Initial Last

Your Healthcare Contacts

Doctor: _____

Advice Nurse: _____

Pharmacy: _____

Call 911 for life threatening emergencies.

IN PARTNERSHIP WITH CONTRA COSTA HEALTH SERVICES

Emergency Contacts

Emergency Contact Name: _____

Phone Number: _____

Relationship: _____

Emergency Contact Name: _____

Phone Number: _____

Relationship: _____

Durable Power of Attorney: _____

Phone Number: _____

Relationship: _____

DNR / POLST (Do Not Resuscitate): Yes / No
If yes, please assure a copy of the document is available.

PLEASE PROVIDE A SEPARATE LIST OF PRESCRIBED MEDICATIONS

Medication Allergies: Yes / No If yes, please list below.

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Are you bedridden: Yes / No

Are you able to walk without assistance? Yes / No

If no, do you use a: (circle one)

Cane, Walker, Wheelchair, Motorized Scooter

Medical Conditions

PLEASE CHECK AND/OR CIRCLE ALL THAT APPLY

CARDIAC:

- ☐ CABG (Bypass Surgery)
- ☐ Congestive Heart Failure
- ☐ Heart Attack
- ☐ Internal Defibrillator
- ☐ Irregular Heart Rhythm: _____
- ☐ Pacemaker
- ☐ Stent
- ☐ Other: _____

RESPIRATORY

- ☐ Asthma
- ☐ COPD
- ☐ Emphysema
- ☐ Other: _____

PSYCHOLOGICAL:

- ☐ Anxiety
- ☐ Depression or Bipolar Disorder
- ☐ Schizophrenia or Schizoaffective Disorder

OTHER:

- ☐ Alzheimers or Dementia
- ☐ Diabetes
- ☐ GERD or Stomach Ulcers
- ☐ Hepatitis or HIV
- ☐ High Cholesterol
- ☐ Hypertension
- ☐ Kidney Failure (Dialysis: Yes / No)
- ☐ Seizures
- ☐ Stroke or TIA (mini-stroke)
- ☐ Other Medical Conditions:

_____ _____

_____ _____