Otago Exercise Program
Edited Version

Implementation Tools

Note – Items highlighted in yellow should be altered to reflect your local information

Created by:
Genesee County Coalition

Supported by a grant from the Health Foundation for Western and Central New York
OTAGO Exercise Program Referral Form

Patient Name: ____________________________ Date of Birth: ____________
Address: ____________________________________________ Phone#: ____________
Emergency Contact: _________________________ Relationship: ______________ Phone#: ____________
Power of Attorney (if applicable): __________________ Phone#: ____________
Patient’s Primary Care Provider: ____________________________________________
Relevant Specialists: ______________________________________________________
Patient’s Insurance Co.: _________________________________________________
Insurance ID#: __________________________________________________________
Insurance Co. Contact Ph#: _____________________________________________
Current Home Care Service Provider (if applicable, check which one):
   Visiting Nursing Services ___ HCR Homecare ___

Note: If possible, please attach front/back copy of insurance card

SCREENING QUESTIONS-ASSESSMENT FOR FALLS RISK AND IN-HOME SERVICES

Falls risk:
• Have you fallen in the last 12 months? □ Yes □ No
• Are you afraid you will fall? □ Yes □ No
• Do you use a cane, walker, or other □ Yes □ No
device to help you walk?

Otago referral criteria: 2-3 “Yes” responses should result in Otago referral. A single (1) “Yes” response
could result in referral if the caseworker has other supporting information.

In-home services eligibility:
• Do you use a cane, walker, or other □ Yes □ No
device to help you walk?
• Does someone need to help you when you □ Yes □ No
go out to stores, restaurants, or appointments?
• Do you get out of your house or apartment more □ Yes □ No
   often than once a week?

In-home therapy eligibility criteria: Client will most likely be eligible with a “Yes” answer to questions #1
and #2 and a “No” answer to question #3. A “Yes” to question #3 will most likely make the client ineligible.
If the answer to question #3 is “No”, but the answer to question #1 or #2 is also “No” (but not “No” to both)
the caseworker should look for special circumstances that might make the client appear more homebound.
(e.g. the patient doesn’t use and assistive device because at home they hold onto furniture and when going
out they hold onto a family member.)

Caseworker comments: ______________________________________________________
__________________________________________________________________________
__________________________________________________________________________

***Remember to also fax Liability Waiver/Release of Information form as well***
WAIVER OF LIABILITY AND RELEASE OF INFORMATION FORM regarding referral to Falls Prevention Exercise Programs

I, ________________________________, residing at:

(print name of client)

(print address of client)

hereby give my consent to the Genesee County Office for the Aging to release information concerning my name, phone number, address, emergency contact, health insurance coverage, and exercise program eligibility information to the agency of my choice as follows (Select One):

☐ Le Roy Physical Therapy & Village Fitness
  3 West Avenue, Le Roy, NY 14482
  Phone: (585) 768-4550
  Fax: (585) 768-2335

☐ Sports Plus Physical Therapy
  8276 Park Rd, Batavia, NY 14020
  Phone: (585) 343-9496
  Fax: (585) 815-7666

☐ Summit Physical/Occupational Therapy Center
  99 MedTech Drive, Suite 104, Batavia, NY 14020
  Phone: (585) 201-7080
  Fax: (585) 201-7087

☐ Visiting Nursing Association (only if eligible for in-home)
  61 Swan Street, Batavia, NY 14020
  Phone: (585) 344-2894
  Fax: (585) 344-2692

I agree to indemnify, hold harmless, and release Genesee County Office for the Aging, the agency I select above, and these agencies’ staff, volunteers, agents and/or officials from any and all actions, causes of actions, claims, suits, or demands resulting from any act or omission arising out of the home safety assessment. No warranty, either expressed or implied, is intended to be created by the implementation of any exercise programs I may take part in. I understand that it is my responsibility to be sure that my health insurance policy covers such an exercise program and that I may be required to make copayments for the service. I also understand that my provider of choice (selected above) may contact my primary care provider to coordinate with my health insurance provider for coverage approval.

To express my understanding of this Release, I sign here:

______________________________  _______________________
Signature of Client or Representative  Date

______________________________
Relationship of Client Representative (if applicable)

10/2011
WAIVER OF LIABILITY AND RELEASE OF INFORMATION FORM
regarding referral to Independent Living of Genesee Region -Batavia, NY Office
and room by room Falls Risk Assessment

I, ____________________________________________________________, residing at:

(Print name of client)
________________________________________________________,

(print address of client)

hereby give my consent to the Genesee County Office for the Aging to release information concerning my name, phone number, address, emergency contact, and initial home safety assessment information to the Independent Living of Genesee Region -Batavia, NY Office

I give permission to have trained Home Safety Assessment volunteers through the Independent Living of Genesee Region -Batavia, NY office to enter my home to conduct a room by room Home Safety Assessment and to help me identify my risks for falls. I understand that the agencies who come to my home to do the assessment, or help with work needed to help lessen my risk of falls, may require me to sign additional papers.

I agree to indemnify, hold harmless, and release Genesee County Office for the Aging and Independent Living of Genesee Region; and these agencies’ staff, volunteers, agents and/or officials from any and all actions, causes of actions, claims, suits, or demands resulting from any act or omission arising out of the home safety assessment. No warranty, either expressed or implied, is intended to be created by the implementation of any home safety measures.

To express my understanding of this Release, I sign here:

________________________________________________________
Signature of Client or Representative

________________________________________________________
Date

________________________________________________________
Relationship of Client Representative (if applicable)
### ENTRANCE TO FRONT DOOR AND FRONT YARD

- Lack of railings or unstable railing
- Ice or snow on driveway/walkway
- Unresolved

### ENTRANCE TO BACK/SIDE DOOR

- Lack of railings or unstable railing
- Ice or snow on driveway/walkway
- Unresolved

### HALLWAY OR FOYER

- Uneven or slippery floor
- Lack of access to ceiling light
- Unresolved

### LIVING ROOM

- Presence of throw or scatter rug
- Presence of unstable chair
- Unresolved

### KITCHEN

- Cabinet too high or low
- Slippery floor
- Unresolved

### BEDROOM

- Presence of clutter
- Lack of telephone near bed
- Unresolved

### BATHROOM

- Presence of unsafe bath rug
- Slippery tub (lack of bath mat etc.)
- Unresolved

### STAIRCASES

- Lack of railings
- Steps too steep
- Unresolved

### LAUNDRY ROOM/BASEMENT

- Lack of or poor lighting
- Slipping steps w/o carpet/luminous light
- Unresolved

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### Comments

- Comments on any other issues:
- Comments on any other issues:
- Comments on any other issues: