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 device to help you walk?** ☐**Yes** ☐ **No**

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 device to help you walk?** ☐**Yes** ☐ **No**
- **Does someone need to help you when you go out to stores, restaurants, or appointments?** ☐**Yes** ☐ **No**
- **Do you get out of your house or apartment more often than once a week?** ☐ **Yes** ☐ **No**

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*****

Genesee County Office for the Aging

2 Bank Street
Batavia, NY 14020
(585) 343-1611
Fax (585) 344-8559
E-Mail: ofa@co.genesee.ny.us
Website: www.co.genesee.ny.us

PAMELA WHITMORE
Director

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

☐ **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

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

☐ **HCR Homecare** (only if eligible for in-home)
211 East Main Street, Batavia, NY 14020
Phone: (585) 250-4190
Fax: (585) 250-4189

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)

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PAMELA WHITMORE
Director

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)

FALLS PREVENTION
HOME SAFETY CHECKLIST

CLIENT NAME_______________________________________ **DATE**_______________________
RENT ☐ or OWN ☐
ASSESSOR_______________________________________ **VOLUNTEER HOURS**__________

√ Problem	√ Resolved	√ Problem	√ Resolved

ENTRANCE TO FRONT DOOR AND FRONT YARD

- ☐ Lack of railings or unstable railing ☐
- ☐ Lack of lighting at night ☐
- ☐ Lack of an outdoor grab bar ☐
- ☐ Other ______________________ ☐
- ☐ Ice or snow on driveway/walkway ☐
- ☐ Lack of a ramp for wheelchair ☐
- ☐ Unmarked or raised threshold ☐
- ☐ Uneven/ cracked pavement ☐

COMMENTS____

ENTRANCE TO BACK/SIDE DOOR

- ☐ Lack of railings or unstable railing ☐
- ☐ Lack of a ramp for wheelchair ☐
- ☐ Uneven/ cracked pavement ☐
- ☐ Unmarked or raised threshold ☐
- ☐ Ice or snow on driveway/walkway ☐
- ☐ Lack of lighting at night ☐
- ☐ Lack of an outdoor grab bar ☐
- ☐ Other ______________________ ☐

COMMENTS____

HALLWAY OR FOYER

- ☐ Uneven or slippery floor ☐
- ☐ Cluttered area ☐
- ☐ Dark or poor lighting ☐
- ☐ Lack of access to ceiling light ☐
- ☐ Other ______________________ ☐

COMMENTS____

LIVING ROOM

- ☐ Presence of throw or scatter rug ☐
- ☐ Presence of clutter ☐
- ☐ Presence of electric cords across the floor ☐
- ☐ Poor lighting ☐
- ☐ Presence of unstable furniture ☐
- ☐ Presence of unstable chair ☐
- ☐ Difficult to access light switches ☐
- ☐ Not enough space to move around ☐
- ☐ Other ______________________ ☐

COMMENTS____

KITCHEN

- ☐ Cabinet too high or low ☐
- ☐ Not enough counter space ☐
- ☐ Using a stool or a chair to reach things ☐
- ☐ Not enough room to maneuver ☐
- ☐ Presence of throw/scatter rugs ☐
- ☐ Slippery floor ☐
- ☐ Poor lighting ☐
- ☐ Presence of pet underfoot when preparing food ☐
- ☐ Other ______________________ ☐

COMMENTS____

BEDROOM

- ☐ Presence of clutter ☐
- ☐ Presence of electric cords across the floor ☐
- ☐ Unsafe carpet (uneven,torn, curled up) ☐
- ☐ Presence of throw/scatter rug ☐
- ☐ Height of bed (too high/low) ☐
- ☐ Other______________________ ☐
- ☐ Lack of telephone near bed ☐
- ☐ Lack of nightlight ☐
- ☐ Arrangement that cause difficult to reach items (TV remote, lamp) ☐
- ☐ Lack of device to get in/out of bed ☐

COMMENTS____

BATHROOM

- ☐ Presence of unsafe bath rug ☐
- ☐ Lack of grab bars in the tub ☐
- ☐ Lack of grab bars in the shower area ☐
- ☐ Lack of grab bar near toilet ☐
- ☐ Toilet is too high/low ☐
- ☐ Other______________________ ☐
- ☐ Slippery tub (lack of bath mat etc.) ☐
- ☐ Claw foot/tub that is too high to get into ☐
- ☐ Lack of bath chair in shower area ☐
- ☐ Clutter ☐
- ☐ Incorrect placement of grab bars ☐

COMMENTS____

STAIRCASES

- ☐ Lack of or poor lighting ☐
- ☐ Clutter ☐
- ☐ Slippery step without tread/carpet ☐
- ☐ Lack of railings ☐
- ☐ Steps too steep ☐
- ☐ Other______________________ ☐

COMMENTS____

LAUNDRY ROOM/BASEMENT

- ☐ Lack of or poor lighting ☐
- ☐ Lack of railings ☐
- ☐ Clutter ☐
- ☐ Same colored floor at bottom of stairs ☐
- ☐ Slippery steps w/o carpet/luminous light ☐
- ☐ Presence of cords across the floor ☐
- ☐ Steps too steep ☐
- ☐ Other______________________ ☐

COMMENTS____