

# Stay Independent

Falls are the main reason why older people lose their independence.

**Are you at risk?**



A Community Fall Prevention Program supported by:

**COASTAL SENIORS**  
**REDWOOD COAST MEDICAL SERVICES**  
**COAST LIFE SUPPORT DISTRICT**  
**AGING IN PLACE MENDONOMA**

**Listed below are examples of local resources that will help you stay independent.**

Matter of Balance Program  
Strength and Balance Training  
Tai Chi  
Yoga  
Stretch Classes  
Home Safety Inspections  
Behavioral Health Counseling

**For more information, please contact:**

#### COASTAL SENIORS

PO Box 437

24000 South Highway 1

Point Arena, CA 95468

(707) 882-2137

[www.coastalseniors.org](http://www.coastalseniors.org)

#### Redwood Coast Medical Services

46900 Ocean Drive

PO Box 1100

Gualala, CA 95445

(707) 882-6992

Point Arena Health Center

30 Mill St.

Point Arena, CA 95468

Fax (707) 884-9728

[www.rcms-healthcare.org](http://www.rcms-healthcare.org)

## Four things you can do to prevent falls:

- 1 Begin an exercise program to improve your leg strength & balance
- 2 Ask your doctor or pharmacist to review your medicines
- 3 Get annual eye check-ups & update your eyeglasses
- 4 Make your home safer by:
  - ▶ Removing clutter & tripping hazards
  - ▶ Putting railings on all stairs & adding grab bars in the bathroom
  - ▶ Having good lighting, especially on stairs

Your doctor may suggest:

- \* Having other medical tests
- \* Changing your medicines
- \* Consulting a specialist
- \* Seeing a physical therapist
- \* Attending a fall prevention program



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

We would like to thank CDC for permission to use information from their "Stay Independent" brochure.

# Check Your Risk for Falling

## Would you like more information about Fall Prevention in the Mendonoma area?

If so, complete the brief survey to the right and mail or drop it off at either of the organizations listed below. They will review your risks for falling and provide you with local Fall Prevention resources. They can also register you in programs you find interesting:

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These seniors enjoy a walk along the beach on a beautiful day.

Please circle "Yes" or "No" for each statement below.		Why it matters.
YES (2)	NO (0)	I have fallen in the last 6 months. 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 a 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 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 for 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 medicine 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.
<b>Total _____</b>		<b>← Add up the number of points for each "Yes" response. If you scored 4 points or more, you may be at risk for falling. Discuss this brochure with your doctor.</b>

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Would you like us to send this to your medical provider? Yes  No

Provider: \_\_\_\_\_ Provider Fax: \_\_\_\_\_

I understand that I may request a copy of the Notice of Privacy Practices from the Community Fall Prevention Program.

Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_