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MrOS Fracture Report

Participant Telephone Interview

MrOS ID#	Acrostic	Staff ID#	Initial Report Date: Month	Day	Year
EF1ID	EF1ACROS	EF1STAFF		EF1DATE	

Fax completed form to fax server AND mail to Chris Schambach with appropriate documentation within 8 weeks of initial notification of fracture.

1. Complete the MrOS Fracture Source of Report Worksheet. Ensure contact information and hospital information is complete.

2. How many bone locations were involved in this fracture incident?

[ ][ ] locations EF1NOBONE

If more than 6 bone locations, complete an additional Initial Notification form and Fracture Report as needed, using a unique initial notificaiton date. See protocol for details..

3. What bone(s) did your health care provider say were broken? Please list:

Bone 1

EF1BONE1

Location code: EF1CODE1

Side: EF1SIDE1
1 ○ Left 2 ○ Right
3 ○ Not Appl.

Were any x-rays taken of this injury? EF1XRAY1

1 ○ Yes 0 ○ No 8 ○ Don't know

Date of x-ray used for diagnosis:: EF1XDATE1 / /

Contact health care provider to request copy of x-ray.

Comments:

Bone 2

EF1BONE2

Location code: EF1CODE2

Side: EF1SIDE2
1 ○ Left 2 ○ Right
3 ○ Not Appl.

Were any x-rays taken of this injury? EF1XRAY2

1 ○ Yes 0 ○ No 8 ○ Don't know

Date of x-ray used for diagnosis: EF1XDATE2 / /

Contact health care provider to request copy of x-ray.

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MrOS Fracture Report

Participant Telephone Interview

MrOS ID#	Acrostic	Staff ID#	Initial Report Date: Month / Day / Year
EF2ID	EF2ACROS	EF2STAFF	EF2DATE

3 continued . . .

Bone 3

EF2BONE3

Location code: EF2CODE3

Side: EF2SIDE3 — 1 Left 2 Right 3 Not Appl.

Were any x-rays taken of this injury? EF2XRAY3

1 Yes 0 No 8 Don't know

Date of x-ray used for diagnosis: EF2XDATE3 / /

Contact health care provider to request copy of x-ray.

Comments:

Bone 4

EF2BONE4

Location code: EF2CODE4

Side: EF2SIDE4 — 1 Left 2 Right 3 Not Appl.

Were any x-rays taken of this injury? EF2XRAY4

1 Yes 0 No 8 Don't know

Date of x-ray used for diagnosis: EF2XDATE4 / /

Contact health care provider to request copy of x-ray.

Comments:

Bone 5

EF2BONE5

Location code: EF2CODE5

Side: EF2SIDE5 — 1 Left 2 Right 3 Not Appl.

Were any x-rays taken of this injury? EF2XRAY5

1 Yes 0 No 8 Don't know

Date of x-ray used for diagnosis: EF2XDATE5 / /

Contact health care provider to request copy of x-ray.

Comments:

Bone 6

EF2BONE6

Location code: EF2CODE6

Side: EF2SIDE6 — 1 Left 2 Right 3 Not Appl.

Were any x-rays taken of this injury? EF2XRAY6

1 Yes 0 No 8 Don't know

Date of x-ray used for diagnosis: EF2XDATE6 / /

Contact health care provider to request copy of x-ray.

Comments:

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MrOS Fracture Report

Participant Telephone Interview

MrOS ID# EF3ID | Acrostic EF3ACROS | Staff ID# EF3STAFF | Initial Report Date: ___ (Month) / EF3DATE (Day) / ____ (Year)

Circumstances of fracture:

4 **Sources of information:** (Mark all that apply) *all coded as -1*

○ Participant ○ MD/Hospital ○ Contact/Proxy ○ Other *EF3SFOTH*

EF3SFPART *EF3SFMD* *EF3SFCP*

5 **When did the fracture occur?** (For vertebral and non-traumatic fractures, the date of symptom onset.)

__ __ / __ __ / __ __ __ __ *EF3DATEFX*

6 **For vertebral fractures only: Did you go to the doctor because of back pain?**

○ Yes ○ No *EF3BKPAIN*

1 *0*

7 **Could you please tell me how your injury occured?** _____

_____

_____

8 **Degree of trauma:** *EF3FALL*

1 ○ Fall from standing height or less
This includes most injuries due to tripping over something, slipping in the shower or bathtub, or falling out of a chair (unless standing on it), in which the participant lands on the surface at the same height as the surface he was standing on.

2 ○ Fall on stairs, steps or curb
This includes all falls during change of level, such as stepping up or down stairs, steps or curbs.

How many stairs or steps did you fall down? __ __ *EF3STEPS*
Same level=0. Probe: 'How many stairs or steps was it from where you fell to where you landed?"

3 ○ Fall from more than standing height, but NOT on stairs This includes falls from heights such as off a ladder or while standing on a table or chair, off a porch, out of a window, etc. The distance fallen refers to the distance between the standing surface and the surface the participant landed on. Subgroup as follows:

1 ○ From the height of a stool, chair, first rung on a ladder or equivalent (about 20 inches.)

2 ○ From higher than the height of a stool, chair, first rung of a ladder or equivalent. (Greater than or equal to 20 inches.)

EF3HEIGHT

4 ○ Minimal trauma other than a fall
This includes vertebral fractures associated with coughing, stepping down a step, etc. and rib or other fractures associated with turning over in bed,etc.

5 ○ Moderate trauma other than a fall
This includes collisions with objects during normal activities (e.g. stub toe, hit hand against doorframe, walking into door) or twisting or turning ankle (for ankle fractures.)

6 ○ Severe trauma other than a fall
This includes motor vehicle accidents, struck by a car, hit by rapidly moving projectile (golf ball or golf club), assault.

If motor vechile accident, speed of vehicle? __ __ *EF3SPEED*

7 ○ Pathological fractures
Usually associated with cancer in bone.

8 ○ Unknown/Don't know
This includes situations where respondent cannot remember when happened.

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MrOS Fracture Report

Clinic Completed Form

MrOS ID# EF4ID | Acrostic EF4ACROS | Staff ID# EF4STAFF | Initial Report Date: Month / Day EF4DATE / Year

9 Follow-up information:

Vertebral fractures (lumbar and thoracic) and 'uncertain' fractures must have an x-ray included in the Fracture Report.

Date(s) x-ray or report requested:

EF4DATER1 /

EF4DATER2 /

EF4DATER3 /

Date x-ray or report received:

EF4DATERC /

Date of x-ray (if different from Question 5, page 3).

EF4DATEXR /

Comments: _____

10 Does documentation include a radiologist's report?

○ Yes (1) ○ No (0) ○ Uncertain (8) EF4XRAY → Please comment: _____

Does documentation include orthopedic notes, if the x-ray was read by a Board certified Orthopedist?

○ Yes (1) ○ No (0) EF4ORTH

If neither a radiologist's report nor a board certified orthopedists's notes are available, is a copy of the x-ray included?

○ Yes (1) ○ No (0) EF4XR

Please comment: _____

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MrOS Fracture Adjudication

Coordinating Center Completed Form

MrOS ID# EF5ID | Acrostic EF5ACROS | Staff ID# EF5STAFF | Initial Report Date: ___ / EF5DATE / ____ (Month / Day / Year)

Bone 1 Initial diagnosis: Name of bone 1: _____

Physician Adjudicator reviewed? 1 ○ Yes 0 ○ No EF5RVIEW1

Adjudication Code: EF5CON1

Stop. Go to Next Bone or End of Report.

1 ○ Confirmed Fracture 2 ○ Not a fracture 3 ○ Uncertain 4 ○ Unobtainable 5 ○ Undocumented

Final location code, bone 1: EF5CODE1F

Final side, bone 1: 1 ○ Left 2 ○ Right 3 ○ Not Appl. EF5SIDE1F

Date of fracture, bone 1: ___ / ___ / ____ EF5DATE1

Was the fracture a stress fracture? 1 ○ Yes 0 ○ No EF5STRS1

Was the fracture a pathological fracture? 1 ○ Yes 0 ○ No EF5PATH1

Was the fracture near a prosthesis (peri-prosthesis)? ○ Yes ○ No EF5PROS1

1 0

Bone 2

replace 1 with 2 eg EF5PROS1 is EF5PROS2

Bone 3

replace 1 with 3 eg EF5PROS1 is EF5PROS3

Bone 4

replace 1 with 4 eg EF5PROS1 is EF5PROS4

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MrOS Fracture Adjudication

Coordinating Center Completed Form

MrOS ID# EF6ID | Acrostic EF6ACROS | Staff ID# EF6STAFF | Initial Report Date: ____ / EF6DATE / ____
(Month / Day / Year)

Bone 5 Initial diagnosis: Name of bone 5: _____

Physician Adjudicator reviewed? 1 ○ Yes 0 ○ No EF6RVIEW5

Adjudication Code: EF6CON5

Stop. Go to Next Bone or End of Report.

1 ○ Confirmed Fracture 2 ○ Not a fracture 3 ○ Uncertain 4 ○ Unobtainable 5 ○ Undocumented

Final location code, bone 5: EF6CODE5F

Final side, bone 5: 1 ○ Left 2 ○ Right 3 ○ Not Appl. EF6SIDE5F

Date of fracture, bone 5: ____ / ____ / ____ EF6DATE5

Was the fracture a stress fracture? 1 ○ Yes 0 ○ No EF6STRS5

Was the fracture a pathological fracture? 1 ○ Yes 0 ○ No EF6PATH5

Was the fracture near a prosthesis (peri-prosthesis)? ○ Yes ○ No EF6PROS5
1 0

Bone 6

replace 5 with 6 eg EF6PROS5 is EF6PROS5

Comments:

Signature of Physician Adjudicator:

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MrOS_EF6_FractureAdjudicationV2

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MrOS Fracture Initial Notification

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MrOS ID# EFXID | Acrostic EFXACROS | Staff ID# EFXSTAFF | Initial Report Date: Month / Day / Year EFXDATE

Submit completed form to the data system within 5 working days of clinic notification of the fracture.

1 Did you see a doctor or health care provider for your injury? *EFXDOCTOR*

- ○ Yes *1* → Complete and send this page to the CC immediately. Complete Fracture Report.
- ○ No *0* → Does participant plan to see a health care provider for his injury?
  - ○ Yes *1* → *EFXDRPLAN* Contact participant after he has seen physician for injury or after 4 weeks,which ever is shorter. Complete form at that time.
  - ○ No *0* → Complete and send this form **ONLY** to CC. Do not complete Fracture Report.
- ○ Participant refused to provide information *3* → Complete and send this form **ONLY** to CC. Do not complete Fracture Report.

2 Date of fracture: Month / Day / Year *EFXDATEFX*

Date of fracture must be after enrollment date.

3 Date fracture reported to clinic: Month / Day / Year *EFXDATERP*

4 Source of report: *EFXSOURCE*

- *1* ○ Participant calls clinic
- *2* ○ Surrogate calls clinic
- *3* ○ Returned tri-annual questionnaire
- *4* ○ Follow-up telephone call for tri-annual questionnaire
- *5* ○ MrOS Clinic Visit (not baseline)
- *6* ○ Health care provider
- *7* ○ Hospital discharge record
- *8* ○ Death certificate
- *9* ○ Other, please specify: _____

5 Complete the MrOS Fracture Contact Information Worksheet. Ensure contact information and hospital information is complete.

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MrOS_EFX_FractureInitialNotificationV3

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