**Adapted NHFD120-day follow-up questionnaire post-hip fracture –** All patients

<Insert hospital logo and department details>

Patient Name:

Hospital No: Date:

**How are you doing?**

We would like to know how you are getting on after your fracture, to help us improve the care we offer to future patients.

1. **Have you been back into hospital since then for any reason?**

Yes No (if ‘Yes’ then please give details)

1. **How do you usually get around now**?

Freely mobile without any aids

Mobile outdoors with one aid (stick or crutch)

Mobile outdoors with two aids or frame

Some indoor mobility but don’t go out without help

Unable to mobilise except with a wheelchair

1. **Where are you living now?**

My usual home address

In a care home- temporarily

With friends or relatives- temporarily

In a care home- permanently

With friends or relatives- permanently

1. **Will this be your permanent address over the next year?**

Yes No (if ‘No’ then please give details)

1. **How satisfied were you with the care you received in hospital (with your hip fracture):**

How likely are you to recommend this hospital to friends and family if they were to need similar care or treatment?

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Extremely |  | Neither likely |  | Extremely | Don’t |
| Likely | Likely | nor unlikely | Unlikely | unlikely | know |

1. **Is there anything you would like us to change?**

**Adapted NHFD120-day follow-up questionnaire post-hip fracture –** only sent to patients who were started on oral bone protection medication

<Insert hospital logo and department details>

Patient Name:

Hospital No: Date:

**Bone strengthening**

When you were with us after your recent hip fracture, we recommended you to take Alendronate tablets to be taken first thing after getting up one morning each week, washed down with a large glass of tap water, avoiding all other food and drink and medicines for at least half an hour afterward taking the tablet.

We enclose an information sheet explaining more about this treatment.

As part of routine follow-up, we would just like to check:

1. **Are you still taking this weekly tablet, which we would recommend continues for the next ten years?**

Yes No

1. **Have you had any problems taking this treatment?**

Yes No (if ‘Yes’ then please give details)

We also recommended that you take supplements of vitamin D (cholecalciferol), sometimes this is taken as a tablet combined with calcium?

1. **Are you still taking these?**

Yes No

1. **Have you had any problems getting a repeat prescription for either of these medicines?**

Yes No (if ‘Yes’ then please give details)

1. **If you’ve had to stop taking these medicines, or are concerned about possible side-effects, would you like to be seen in our bone outpatient clinic to discuss alternative osteoporosis treatment options?**

Yes No

**Thank you for your time completing this short questionnaire.**