

# TeleFFIT Study – Initial Consultation (via Zoom) for Local Clients

Participant ID Number      Participant Initials   Site

## CLIENT PRE – INITIAL CONSULTATION REVIEW

Date of visit: \_\_\_/\_\_\_/\_\_\_ (DD / MMM / YYYY) Time of visit: \_\_\_:\_\_\_ (AM / PM) Initials of EP: \_\_\_\_\_  
(HH : MM)

### Client contact information

First name: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Emergency contact name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
 Emergency Contact Phone: \_\_\_\_\_

### Summary notes by the EP based on each client’s health, medical and lifestyle assessment

#### Fracture risk assessment (DXA bone density) – one tick for each skeletal site

	Normal BMD <small>(T-score &gt; -1.0 SD)</small>	Osteopenia <small>(T-score -1.0 to &lt; -2.5 SD)</small>	Osteoporosis <small>(T-score -2.5 to -3.0 SD)</small>	Severe Osteoporosis <small>(T-score &lt; -3.0 SD)</small>
Femoral neck	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Total hip	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lumbar spine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

#### Falls and fracture history and functional status

		Yes	No
Recent fall(s).	If yes, number _____	<input type="checkbox"/>	<input type="checkbox"/>
Minimal trauma fracture since the age of 50	Site: _____	<input type="checkbox"/>	<input type="checkbox"/>
Five times Sit to Stand test (cut off > 15 seconds)	Score _____	<input type="checkbox"/>	<input type="checkbox"/>
Low muscle (grip) strength (men < 27 kg; women < 16 kg):	Score _____	<input type="checkbox"/>	<input type="checkbox"/>
Impaired muscle function (SPPB < 9):	Score _____	<input type="checkbox"/>	<input type="checkbox"/>
Slow gait speed (≤ 0.8 m/sec):	Score _____	<input type="checkbox"/>	<input type="checkbox"/>
Frailty: Robust = 0   Pre-frail = 1-2   Frail ≥3	Score _____	<input type="checkbox"/>	<input type="checkbox"/>

Additional Notes / Comments:

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**Relevant past medical history:**

*This will be auto filled*

**Medications:**

*This will be auto filled*

Completed by (initials): \_\_\_\_\_

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**Past physical activity experience:**

*This will be auto filled*

**Reported key motivators for exercise / physical activity:**

*This will be auto filled*

Completed by (initials): \_\_\_\_\_

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**Reported key barriers to exercise / PA:**

*This will be auto filled*

**Reported personal goals:**

*This will be auto filled*

Completed by (initials): \_\_\_\_\_

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## INITIAL CONSULTATION GUIDE (Part 1) & CHECKLIST

<b>Exercise practitioner initials:</b> ____	<b>Date:</b> ____ / ____ / ____ <small>(DD / MMM / YYYY)</small>
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### 1. INTRODUCTION

*Firstly introduce yourself, provide an overview of the procedures for the appointment today.*

Hi my name is \_\_\_\_\_ and I will be the Exercise Physiologist/Physiotherapist looking after you through the 12-month TeleFFIT study. As you would have read, we will be meeting a few times in the next few weeks.

In today's session we will run through what's required for TeleFFIT, collaboratively discuss and set some goals you'd like to achieve by taking part in this study, create a plan that will help you achieve your goals and lead to a stronger, steadier and healthier body. I will then come to your home \_\_\_\_\_ week and we will run through how to use the exercise app to complete your exercise program, check that you have a safe place to exercise and then undertake some of your exercises.

We'll also be in regular contact with one another throughout the study via the exercise app/website and email/phone and we will meet via Zoom again on 10 occasions over the 12 months to discuss how you're going with the program, but you can contact me via the app/email/phone at any time.

<b>1.2</b> If needed/requested by client: Provide an overview of the TeleFFIT exercise program requirements and/or answer any client questions.  <i>[NB. Participants are asked to watch 8 instructional videos (available on their website) prior to meeting with you, which explain each component of the TeleFFIT exercise program (i.e. Strong, Steady, Straight &amp; Activity snack exercises)]</i>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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<b>1.3</b> Discuss your client's health, medical and lifestyle history with them where relevant.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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	Medical history/injury notes: <div style="border: 1px solid black; height: 150px; margin-top: 5px;"></div>
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<b>1.4</b> Where do you plan to complete your exercise program?	<input type="checkbox"/> At home	<input type="checkbox"/> At a gym/facility
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Completed by (initials): \_\_\_\_\_

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## 2. SETTING GOALS

I would now like to discuss your main goals for participating in the TeleFFIT program. We have noted that you set some goals when completing the online questionnaire. I would now like us to discuss these goals, including short-term goals (for the next 2-4 weeks), medium term goals (for the next 3 months) and your long-term goals (for the 12-month program) NB. Client goals should be SMART (Specific, Measurable, Achievable, Relevant, Time-bound) and include behaviour related goals and not just outcome focused where possible.

2.1 What are your **short-term goals** for the next 2-4 weeks?

How do you expect to achieve these goals (e.g., list specific days or times you might exercise)?

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2.2 What are your **medium-term goals** (e.g., for the next 3 months) with regards to the TeleFFIT exercise program? How do you expect to achieve these goals?

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2.3 What are your **long-term goals** (e.g., for the 12 months) with regards to the TeleFFIT exercise program? How do you expect to achieve these goals?

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## 5. Schedule / Confirm Video Health Coaching Consultations

Together we will have a home visit, and then 10 video consultations throughout the study using Zoom. Let's schedule / confirm the date and time of your home visit & first 2 consultations.

<b>5.1</b>	Home Visit consultation: Date _____ / _____ / 20_____ Time _____ : _____ AM / PM via Zoom / Phone / _____
<b>5.2</b>	Week 2 consultation: Date _____ / _____ / 20_____ Time _____ : _____ AM / PM via Zoom / Phone / _____
<b>5.3</b>	Week 4 consultation: Date _____ / _____ / 20_____ Time _____ : _____ AM / PM via Zoom / Phone / _____
<b>5.4</b>	<p>Run participant through using Email/Zoom/Phone/App to:</p> <p><input type="checkbox"/> How to best contact their EP throughout program (email VS phone call VS text)</p> <p><input type="checkbox"/> Video calls with their EP/Dietitian (on Zoom)</p> <p><input type="checkbox"/> Educate that will be able to leave messages for EP in TeleHab</p> <p><u>Re: Zoom</u></p> <p>If client not confident on how to use Zoom, may need further assistance by EP.</p> <ul style="list-style-type: none"> <li>- EP to run through their questions about Zoom at end of session (if time)</li> <li>- Direct participant to 'Tips on Using Zoom' information sheet on TeleFFIT website:</li> </ul> <p><a href="https://teleffit.com.au/wp-content/uploads/sites/221/2022/03/Tips-on-using-Zoom.pdf">https://teleffit.com.au/wp-content/uploads/sites/221/2022/03/Tips-on-using-Zoom.pdf</a></p>

## 6. Final Checklist for EPs (tick when completed)

- Collaboratively define your clients short and long-term exercise goals using SMART principles.
- Review potential barriers & facilitators to exercise participation & discuss strategies to overcome them.
- Discuss with your client how to download the TeleHab exercise app OR access website
- Schedule/confirm the home visit + 2 x Zoom-based follow-up consultations (week 2 and 4)

Completed by (initials): \_\_\_\_\_

