



MONASH University
Accident Research Centre

FARM INJURY RISK AMONG MEN (FIRM) STUDY



Case (non-fatal) Questionnaire (v10)
(Farm employees)

ID: _____

DATE OF INTERVIEW: ____/____/200__

Interviewer: _____

Interview method: Face to face Telephone

Consent form completed & returned: Yes No

(Attach completed consent to be contacted (short) form, verbal consent sign-off form, log page & full consent forms (if returned) to this questionnaire.)

Introduction:

- Introduce self and explain purpose of visit.
- If patient did not receive project description and full consent form in emergency department, then give those to patient and allow time to read the statement.
- Answer any questions that the patient may have.
- Follow guidelines for determining informed consent provided in the kit
- Once full consent form is signed (if 'face to face' contact) proceed with the interview and complete the questionnaire.
- If contacting patient over the telephone, once verbal consent is given, proceed with the interview and complete questionnaire. At the end of the interview, obtain postal details and send them the full consent form (medical records access) with a reply paid envelope.

Note to interviewer (for employees only):

The participant may not be able to answer some of these questions, particularly if he is a farm employee rather than the manager or owner. If there is one or more questions that he can't answer, then choose the "Don't know" option and move on to the next question.

Interviewer:

"The questions in this interview are in three sections: some are about the farm where you work, some are about yourself, and some are about the injury and the day it happened. We do not expect that you will necessarily know the answers to all of the questions. If you don't really know an answer, there is no need to estimate or guess, simply reply that you don't know or are not sure. I'd like to start with some questions about the farm where you work."

A. Farm Characteristics

A1a. In terms of income, what is the most important (1) and the second most important (2) commodity group produced on the farm on which you work?

(Place the number 1 in the box next to the selection that most matches their response for the most important and the number 2 in the box next to the selection that most matches their response for the second most important commodity, if any).

NOTE: If only 1 commodity, skip Question A1b.

Poultry Farming

1. Poultry (meat)

2. Poultry (eggs)

Horticulture & Fruit Growing

3. Plant nurseries

4. Cut flower & flower seed growing

5. Potato growing

6. Vegetable growing

7. Grape growing

8. Fruit growing

Grain, sheep & beef cattle farming

9. Grains (wheat, barely, oats etc.)

10. Grain & sheep farming

11. Grain & beef cattle farming

12. Grain/sheep/beef cattle farming

13. Sheep & beef cattle farming

14. Sheep farming (wool)

15. Sheep farming (meat)

16. Sheep (wool & meat)

17. Beef cattle farming

18. Dairy cattle (milk) farming

Other livestock farming

19. Pig farming

20. Horse farming

21. Deer farming

22. Livestock farming NEC

Other crop growing

23. Sugar cane growing

24. Cotton growing

Services to agriculture; Hunting & trapping

25. Sheep shearing services

26. Cotton ginning

27. Agistment

28. Hunting & trapping

29. Forestry

30. Logging

31. Other services to agriculture (specify) _____

Other

95. Other _____

96. Can't recall/don't know

97. Prefer not to answer

98. Not applicable

99. Missing

A1b. In the past 12 months, which commodity, if more than one, would you have spent the most working hours on? (Circle their response above using the corresponding code.)

A2. What size is the property?

(Tick appropriate box or record **acres** if hectares unknown) _____ acres

- 1. 0 – 99 hectares
- 2. 100 – 499 hectares
- 3. 500 – 999 hectares
- 4. 1000 – 2499 hectares
- 5. Over 2500 hectares

- 96. Can't recall/don't know
- 97. Prefer not to answer
- 98. Not applicable
- 99. Missing

A3. Do you know how many operational tractors greater than 560 kgs (1/2 metric tonne) are on the property?

- Don't know Go to A5
- None 0 Go to A5
- One or more (*specify number*) _____ Go to A4

A4. How many of those tractors have the following features?

(Note: DK = Don't know)

- a. Roll over protective frame _____ None DK
- b. Power take off (PTO) master shield/output guard _____ None DK
- c. Neutral start switch _____ None DK
- d. Hazard alert symbol or other safety signs _____ None DK
- e. How many with a seat belt _____ None DK
- f. How many have an enclosed cabin _____ None DK

Please indicate year(s) of manufacture of your **cabin tractors** _____

- g. How many **do not** have an enclosed cabin or roll over frame? _____ None DK
- h. How many are fitted with a front-end loader? _____ (If 0, skip to A5)
- i. Of those with a front end loader, how many have roll back protection? _____ None DK

A5. Could you tell me which of the following items on personal protective equipment are kept on the property? (Tick the appropriate box)

<i>Activity</i>	<i>Equipment</i>	<i>(1)</i> <i>Yes</i>	<i>(2)</i> <i>No</i>	<i>(96)</i> <i>Can't Recall/ Don't Know</i>	<i>(97)</i> <i>Prefer not to answer</i>	<i>(98)</i> <i>Not applicable (I/we do not perform workshop activities)</i>
1. For workshop activities:	1. Ear muffs/plugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	2. Safety goggles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		<i>Yes</i>	<i>No</i>	<i>Can't Recall/ Don't Know</i>	<i>Prefer not to answer</i>	<i>Not applicable (I/we do not mix/prepare chemicals)</i>
2. For mixing & preparing chemicals:	1. Face mask/Dust mask	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	2. Respirator (filters gasses & particles)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	3. Protective face shield	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	4. Disposable coveralls	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	5. Gloves	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		<i>Yes</i>	<i>No</i>	<i>Can't Recall/ Don't Know</i>	<i>Prefer not to answer</i>	<i>Not applicable (I/we do not have ag bikes or horses on the property)</i>
3. For getting around:	1. Helmet for Ag bikes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	2. Helmet for horse riding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

A6. Do you know how often passengers are carried on the property on tractors that don't have a manufacturer's designed passenger seat fitted?

Always Often Half the time Not often Never N/A Don't know

1 _____ 2 _____ 3 _____ 4 _____ 5 _____ 6 _____ 7

A7. Do you know how often maintenance of farm machinery is carried out on the property to a regular or manufacturer's recommended schedule?

Always Often Half the time Not often Never N/A Don't know

1 _____ 2 _____ 3 _____ 4 _____ 5 _____ 6 _____ 7

A8. Do you know how often people operating tractors on the property climb on or off before the machine comes to a complete stop?

Always Often Half the time Not often Never N/A Don't know

1 _____ 2 _____ 3 _____ 4 _____ 5 _____ 6 _____ 7

A9. Do you know if anyone currently working on the property has ever done safety training? (Tick box)

1. Yes (Go to A9a & A9b)

2. No (Go to A10)

96. Can't recall/ don't know

98. Not applicable

97. Prefer not to answer

99. Missing

A9a. If yes, was it in the last 12 months? (Tick box)

1. Yes

2. No

96. Can't recall/don't know

98. Not applicable

97. Prefer not to answer

99. Missing

A9b. If yes to A9, did this include yourself (at any time)? (Tick box)

1. Yes

2. No

96. Can't recall/don't know

98. Not applicable

97. Prefer not to answer

99. Missing

A10. Do you know if a formal safety check has ever been conducted on the property? By this I mean someone walking around the property using a checklist to note problems.

1. Yes (Go to A11)

2. No (Go to AE12)

96. Can't recall/don't know

98. Not applicable

97. Prefer not to answer

99. Missing

A11. Do you know when the last check was done? (Tick box)

1. Under 1 month ago

2. 1 – 3 months ago

3. 3 – 6 months ago

4. 6 – 12 months ago

5. Over 12 months ago

96. Can't recall/don't know

97. Prefer not to answer

98. Not applicable

99. Missing

AE12. In the past 3 years, do you know if there have been any major changes related to the farm or farm work? (Tick one or more boxes in column A then ask:) and which of these changes have occurred in the last 12 months? (Tick one or more boxes in column B)

	A. Last 3 years...	B. Last 12 mths...
1. increase or decrease in total area (beyond year to year variation)	A1. <input type="checkbox"/>	B1. <input type="checkbox"/>
2. increase or decrease in number of animals (beyond year to year variation)	A2. <input type="checkbox"/>	B2. <input type="checkbox"/>
3. increase or decrease in area under crop	A3. <input type="checkbox"/>	B3. <input type="checkbox"/>
4. increase or decrease in commodity prices	A4. <input type="checkbox"/>	B4. <input type="checkbox"/>
5. staff changes	A5. <input type="checkbox"/>	B5. <input type="checkbox"/>
6. ownership changes	A6. <input type="checkbox"/>	B6. <input type="checkbox"/>
7. changes in production methods	A7. <input type="checkbox"/>	B7. <input type="checkbox"/>
8. new equipment	A8. <input type="checkbox"/>	B8. <input type="checkbox"/>
9. other (specify) _____	A9. <input type="checkbox"/>	B9. <input type="checkbox"/>
96. Can't recall/don't know	A96. <input type="checkbox"/>	B96. <input type="checkbox"/>
97. Prefer not to answer	A97. <input type="checkbox"/>	B97. <input type="checkbox"/>
98. Not applicable	A98. <input type="checkbox"/>	B98. <input type="checkbox"/>
99. Missing	A99. <input type="checkbox"/>	B99. <input type="checkbox"/>

“The next two questions concern serious farm-work related injuries occurring on the farm. A farm-work related injury can be a cut, sprain, dislocated or broken bone, falls, animal handling injuries and machine and power tool related injuries. A serious injury is one that would require professional medical care and/or the injured person not being able to work for a day or more or not working at the same pace for 5 days or more.”

AE13. Do you know if there have been any serious farm-work related injuries on the farm in the last 12 months (excluding your current injury)? *(Tick box)*

- | | | |
|---------------------------------|--|---|
| 1. <input type="checkbox"/> Yes | 96. <input type="checkbox"/> Can't recall/don't know | 98. <input type="checkbox"/> Not applicable |
| 2. <input type="checkbox"/> No | 97. <input type="checkbox"/> Prefer not to answer | 99. <input type="checkbox"/> Missing |

AE14. Do you know if there have been any serious farm-work related injuries on the farm in the last 3 years (excluding your current injury)? *(Tick box)*

- | | | |
|---------------------------------|--|---|
| 1. <input type="checkbox"/> Yes | 96. <input type="checkbox"/> Can't recall/don't know | 98. <input type="checkbox"/> Not applicable |
| 2. <input type="checkbox"/> No | 97. <input type="checkbox"/> Prefer not to answer | 99. <input type="checkbox"/> Missing |

AE15. Do you know what the average annual income of the property before tax is? *(Tick box)*

- | | |
|---|--|
| 1. <input type="checkbox"/> <\$4999 | 96. <input type="checkbox"/> Can't recall/don't know |
| 2. <input type="checkbox"/> \$5000-\$22,500 | 97. <input type="checkbox"/> Prefer not to answer |
| 3. <input type="checkbox"/> \$22,500-\$50,000 | 98. <input type="checkbox"/> Not applicable |
| 4. <input type="checkbox"/> \$50,000 -\$100,000 | 99. <input type="checkbox"/> Missing |
| 5. <input type="checkbox"/> >\$100,000 | |

AE16. From the list that I will read, would you be able to categorise the farm's current debt load and, in your opinion, what would it be? *(Tick box)*

- | | |
|------------------------------------|--|
| 1. <input type="checkbox"/> None | 96. <input type="checkbox"/> Can't recall/don't know |
| 2. <input type="checkbox"/> Small | 97. <input type="checkbox"/> Prefer not to answer |
| 3. <input type="checkbox"/> Medium | 98. <input type="checkbox"/> Not applicable |
| 4. <input type="checkbox"/> Large | 99. <input type="checkbox"/> Missing |

AE17. Including family members and hired workers, do you know how many people worked on the farm around the _____ ? (insert injury date of case)

_____ no. of workers (incl. family)

96. Can't recall/don't know

98. Not applicable

97. Prefer not to answer

99. Missing

Note to interviewer: As the case subject is not the owner/manager of the property ask the following:

A18. We understand that you may not have been able to answer some of the questions about the farm yourself. Would you be willing to provide us with contact details for the owner/manager so that we can ask him/her some questions about the farm? Before you answer, we would like to remind you that all information provided by you is strictly confidential.

Yes (Insert contact details & survey id onto farm owner/manager contact list)

No

B. Personal Characteristics

“Now some questions about you.”

B1. Would you say you work primarily in the agricultural industry?

Yes (Go to B1a & B1b)



B1a. Please describe the nature of your involvement in farming?

- 1. Full time, all year round
- 2. Full time, seasonal
- 3. Part time, all year round
- 4. Part time, seasonal
- 6. Other, (please specify)

96. Can't recall/don't know

97. Prefer not to answer

98. Not applicable

99. Missing

B1b. What is your position on the farm?

Position/Job Title:

Go to B4



No (Go to B2)



B2. What is your main occupation?

B3. What is your employer's main kind of business?

Go to B4



B4. Do you have a second job?

Yes (Go to B4a & B4b)

No

Go to B5.



B4a. What is that job/position? _____

B4b. What is your employer's main kind of business? _____

B5. What is your date of birth (month & year)? _____ / 19_____
(MM) (YY)

B6. With which hand do you prefer to perform most tasks?

- 1. Right
- 2. Left
- 3. Both

- | | |
|--|---|
| 96. <input type="checkbox"/> Can't recall/don't know | 98. <input type="checkbox"/> Not applicable |
| 97. <input type="checkbox"/> Refused | 99. <input type="checkbox"/> Missing |

B7. In your lifetime, how many years have you been doing farm work? (Tick box)

- 1. Under 1 year
- 2. 1 – 4 years
- 3. 5 – 9 years
- 4. 10 – 20 years
- 5. Over 20 years

- | |
|--|
| 96. <input type="checkbox"/> Can't recall/don't know |
| 97. <input type="checkbox"/> Prefer not to answer |
| 98. <input type="checkbox"/> Not applicable |
| 99. <input type="checkbox"/> Missing |

B8. Did you: (Tick appropriate box)

- 1. Grow up on a farm?
- 2. Come to farming as an adult?

- | |
|--|
| 96. <input type="checkbox"/> Can't recall/don't know |
| 97. <input type="checkbox"/> Prefer not to answer |
| 98. <input type="checkbox"/> Not applicable |
| 99. <input type="checkbox"/> Missing |

B9. What is your highest level of education? (Tick box)

- 1. Primary
- 2. Some high school
- 3. Completed high school
- 4. Some university
- 5. Completed undergraduate university studies
- 6. Completed postgraduate university studies
- 7. TAFE
- 8. Other (specify) _____

- | |
|--|
| 96. <input type="checkbox"/> Can't recall/don't know |
| 97. <input type="checkbox"/> Prefer not to answer |
| 98. <input type="checkbox"/> Not applicable |
| 99. <input type="checkbox"/> Missing |

B10. Have you completed any educational or training courses specific to farming?

1. Yes

2. No

96. Can't recall/don't know

98. Not applicable

97. Prefer not to answer

99. Missing

If yes, what were these courses?

“The next questions concern serious farm-work related injuries **YOU** may have suffered whilst employed on a farm including such injuries as a cut, sprain, dislocated or broken bone, falls, animal handling injuries and machine and power tool related injuries. A serious injury is one that would require professional medical care and/or not being able to work for a day or more or not working at the same pace for 5 days or more.”

B11. In the last 3 years, have you suffered any other serious farm/work related injuries (excluding your current injury) which required time off work for 4 hours or more or medical attention? (Tick box)

1. Yes Go to B12

2. No Go to B14

96. Can't recall/don't know

97. Prefer not to answer

98. Not applicable

99. Missing

B12. How many of these injuries have you had in the last 3 years? _____

B13. How many of these injuries resulted in an overnight stay in hospital? _____

B14. In the past 12 months, have you had any medical conditions for which you have taken medicine regularly?

1. Yes Go to B15

2. No Go to B17

96. Can't recall/don't know

98. Not applicable

97. Prefer not to answer

99. Missing

B15. What were these medical conditions?

B16. What were these medications? *(List type of medication, eg. Water pill, if they don't know the name of medicine.)*

B17. Has a doctor told you that you have any of the following chronic medical conditions or events? *(Tick those already mentioned in B15 but do not check or correct from medical records.)*

<u>Condition:</u>	Yes	No	Don't know	Prefer not to answer
a Ulcer/ stomach upsets	1. <input type="checkbox"/>	2. <input type="checkbox"/>	3. <input type="checkbox"/>	4. <input type="checkbox"/>
b High blood pressure	1. <input type="checkbox"/>	2. <input type="checkbox"/>	3. <input type="checkbox"/>	4. <input type="checkbox"/>
c Heart attack	1. <input type="checkbox"/>	2. <input type="checkbox"/>	3. <input type="checkbox"/>	4. <input type="checkbox"/>
d Arthritis or rheumatism	1. <input type="checkbox"/>	2. <input type="checkbox"/>	3. <input type="checkbox"/>	4. <input type="checkbox"/>
d Asthma	1. <input type="checkbox"/>	2. <input type="checkbox"/>	3. <input type="checkbox"/>	4. <input type="checkbox"/>
f Urinary incontinence or disturbances of the urinary system	1. <input type="checkbox"/>	2. <input type="checkbox"/>	3. <input type="checkbox"/>	4. <input type="checkbox"/>

B18. In the last 12 months, have you had back pain?

1. Yes

2. No

96. Can't recall/don't know

98. Not applicable

97. Prefer not to answer

99. Missing

B19. In the last 12 months, have you stopped using any prescribed medication for pain relief that you had been taking regularly?

1. Yes (Go to B20)

2. No (Go to B21)

96. Can't recall/don't know

98. Not applicable

97. Prefer not to answer

99. Missing

B20. If yes, when did you stop and what was the medication?

1. Less than 1 month ago

2. 1 month ago

3. 1½ months ago

4. 2 months ago

96. Can't recall/don't know

97. Prefer not to answer

98. Not applicable

99. Missing

Medication(s):

B21. In the last 12 months, have you stopped using any prescribed medication for arthritis that you had been taking regularly?

1. Yes (Go to B22)

2. No (Go to B23)

96. Can't recall/don't know

98. Not applicable

97. Prefer not to answer

99. Missing

B22. If yes, when did you stop and what was the medication?

1. Less than 1 month ago

2. 1 month ago

3. 1½ months ago

4. 2 months ago

96. Can't recall/don't know

97. Prefer not to answer

98. Not applicable

99. Missing

Medication(s):

B23. At the present time, would you say that your eyesight using both eyes (with glasses or contact lenses, if you wear them) is?

1. Excellent

2. Good

3. Fair

4. Poor

5. Very poor

96. Can't recall/don't know

97. Prefer not to answer

98. Not applicable

99. Missing

B24. What type of glasses do you usually wear? (Can tick more than one option)

1. No glasses

2. Reading glasses only

3. Long distance glasses

4. Bifocals or trifocals

5. Multifocals

6. Contact lenses

96. Can't recall/don't know

97. Prefer not to answer

98. Not applicable

99. Missing

B25. When did you last have your eyes examined by an optometrist or ophthalmologist (eye doctor)?

1. Under 1 month ago

2. 1 – 6 months ago

3. 7 – 12 months ago

4. 13 – 18 months ago

5. 19 - 24 months ago

6. Over 2 years ago

7. Never

96. Can't recall/don't know

97. Prefer not to answer

98. Not applicable

99. Missing

B26. During the last year, did you usually use a hearing aid?

- | | | |
|---|--|---|
| 1. <input type="checkbox"/> Yes (Go to B27) | 96. <input type="checkbox"/> Can't recall/don't know | 98. <input type="checkbox"/> Not applicable |
| 2. <input type="checkbox"/> No (Go to B28) | 97. <input type="checkbox"/> Prefer not to answer | 99. <input type="checkbox"/> Missing |

B27. With your hearing aid on, do you consider your hearing to be? (Tick box)

- | | |
|---------------------------------------|--|
| 1. <input type="checkbox"/> Excellent | 96. <input type="checkbox"/> Can't recall/don't know |
| 2. <input type="checkbox"/> Good | 97. <input type="checkbox"/> Prefer not to answer |
| 3. <input type="checkbox"/> Fair | 98. <input type="checkbox"/> Not applicable |
| 4. <input type="checkbox"/> Poor | 99. <input type="checkbox"/> Missing |
| 5. <input type="checkbox"/> Very poor | |

B28. I would now like to ask some questions about sleepiness in the past 4-6 weeks. Even if you did not do some of the things I am going to mention in the past 4-6 weeks, try to work out how they would have affected you.

<i>In the past 4-6 weeks, how likely were you to doze off or fall asleep in the following situations?</i>	Never	Slight chance	Moderate chance	High chance
<i>Please respond by choosing one of the following categories for each situation:</i>	0	1	2	3
i. sitting and reading...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ii. watching TV...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
iii. sitting inactive in a public place...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
iv. being a passenger in a car for an hour without a break...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
v. lying down to rest in the afternoon when circumstances permit...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
vi. sitting and talking to someone...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
vii. sitting quietly after a lunch without alcohol...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
viii. in a car, while stopped for a few minutes in traffic...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

“Now I am going to ask you some questions about your use of alcoholic beverages during the past year. By alcoholic beverages we mean your use of wine, beer and spirits.”

B29. How often do you have a drink containing alcohol?

- | | |
|---|--|
| 0. <input type="checkbox"/> Never (<i>Go to next section, Question C1, page 19</i>) | 96. <input type="checkbox"/> Can't recall/don't know |
| 1. <input type="checkbox"/> Monthly or less | 97. <input type="checkbox"/> Prefer not to answer |
| 2. <input type="checkbox"/> 2 to 4 times a month | 98. <input type="checkbox"/> Not applicable |
| 3. <input type="checkbox"/> 2 to 3 times a week | 99. <input type="checkbox"/> Missing |
| 4. <input type="checkbox"/> 4 or more times a week | |

B30. How many drinks containing alcohol do you have on a typical day when you are drinking?

- | | |
|--|--|
| 0. <input type="checkbox"/> 1 or 2 | 96. <input type="checkbox"/> Can't recall/don't know |
| 1. <input type="checkbox"/> 3 or 4 | 97. <input type="checkbox"/> Prefer not to answer |
| 2. <input type="checkbox"/> 5 or 6 | 98. <input type="checkbox"/> Not applicable |
| 3. <input type="checkbox"/> 7 or 9 | 99. <input type="checkbox"/> Missing |
| 4. <input type="checkbox"/> 10 or more | |

B31. How often do you have six or more drinks on one occasion?

- | | |
|---|--|
| 0. <input type="checkbox"/> Never | 96. <input type="checkbox"/> Can't recall/don't know |
| 1. <input type="checkbox"/> Less than monthly | 97. <input type="checkbox"/> Prefer not to answer |
| 2. <input type="checkbox"/> Monthly | 98. <input type="checkbox"/> Not applicable |
| 3. <input type="checkbox"/> Weekly | 99. <input type="checkbox"/> Missing |
| 4. <input type="checkbox"/> Daily or almost daily | |

B32. How often during the last year have you found that you were not able to stop drinking once you had started?

- | | |
|---|--|
| 0. <input type="checkbox"/> Never | 96. <input type="checkbox"/> Can't recall/don't know |
| 1. <input type="checkbox"/> Less than monthly | 97. <input type="checkbox"/> Prefer not to answer |
| 2. <input type="checkbox"/> Monthly | 98. <input type="checkbox"/> Not applicable |
| 3. <input type="checkbox"/> Weekly | 99. <input type="checkbox"/> Missing |
| 4. <input type="checkbox"/> Daily or almost daily | |

B33. How often during the last year have you failed to do what was normally expected from you because of drinking?

- | | |
|---|--|
| 0. <input type="checkbox"/> Never | 96. <input type="checkbox"/> Can't recall/don't know |
| 1. <input type="checkbox"/> Less than monthly | 97. <input type="checkbox"/> Prefer not to answer |
| 2. <input type="checkbox"/> Monthly | 98. <input type="checkbox"/> Not applicable |
| 3. <input type="checkbox"/> Weekly | 99. <input type="checkbox"/> Missing |
| 4. <input type="checkbox"/> Daily or almost daily | |

B34. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?

- | | |
|---|--|
| 0. <input type="checkbox"/> Never | 96. <input type="checkbox"/> Can't recall/don't know |
| 1. <input type="checkbox"/> Less than monthly | 97. <input type="checkbox"/> Prefer not to answer |
| 2. <input type="checkbox"/> Monthly | 98. <input type="checkbox"/> Not applicable |
| 3. <input type="checkbox"/> Weekly | 99. <input type="checkbox"/> Missing |
| 4. <input type="checkbox"/> Daily or almost daily | |

B35. How often during the last year have you had a feeling of guilt or remorse after drinking?

- | | |
|---|--|
| 0. <input type="checkbox"/> Never | 96. <input type="checkbox"/> Can't recall/don't know |
| 1. <input type="checkbox"/> Less than monthly | 97. <input type="checkbox"/> Prefer not to answer |
| 2. <input type="checkbox"/> Monthly | 98. <input type="checkbox"/> Not applicable |
| 3. <input type="checkbox"/> Weekly | 99. <input type="checkbox"/> Missing |
| 4. <input type="checkbox"/> Daily or almost daily | |

B36. How often during the last year have you been unable to remember what happened the night before because you had been drinking?

- | | |
|---|--|
| 0. <input type="checkbox"/> Never | 96. <input type="checkbox"/> Can't recall/don't know |
| 1. <input type="checkbox"/> Less than monthly | 97. <input type="checkbox"/> Prefer not to answer |
| 2. <input type="checkbox"/> Monthly | 98. <input type="checkbox"/> Not applicable |
| 3. <input type="checkbox"/> Weekly | 99. <input type="checkbox"/> Missing |
| 4. <input type="checkbox"/> Daily or almost daily | |

B37. Have you or someone else been injured as a result of your drinking?

- | | | |
|---|--|---|
| 0. <input type="checkbox"/> No | 96. <input type="checkbox"/> Can't recall/don't know | 98. <input type="checkbox"/> Not applicable |
| 2. <input type="checkbox"/> Yes, but not in the last year | 97. <input type="checkbox"/> Prefer not to answer | 99. <input type="checkbox"/> Missing |
| 4. <input type="checkbox"/> Yes, during the last year | | |

B38. Has a relative or friend or a doctor or another health worker been concerned about your drinking or suggested you cut down?

- 0. No
- 2. Yes, but not in the last year
- 4. Yes, during the last year

96. Can't recall/don't know

98. Not applicable

97. Prefer not to answer

99. Missing

C. Injury Incident & Exposure

Note to interviewers:

If the patient becomes distressed during this section, offer him/her the opportunity to stop the interview. Remind the patient of the availability of psychological counselling as explained – project description sheet.

“Now some questions about the injury and the day it happened.”

C1. When did your injury occur _____ / _____ ?
(Month) (Year)

C2. What time did you start work on that day? _____ am / pm (Circle)

96. Can't recall/don't know

98. Not applicable

97. Prefer not to answer

99. Missing

C3. What time of day did your injury occur? _____ am / pm (Circle)

96. Can't recall/don't know

98. Not applicable

97. Prefer not to answer

99. Missing

This page is purposefully left blank for future separation from questionnaire once coding and data entry of injury text description has been completed.

This page is purposefully left blank for future separation from questionnaire once coding and data entry of injury text description has been completed.

M. Machinery Characteristics

“The following questions refer to the machine which was involved in your injury.”

M1. Do you know who manufactured this machine? _____

96. <input type="checkbox"/> Can't recall/don't know	98. <input type="checkbox"/> Not applicable
97. <input type="checkbox"/> Prefer not to answer	99. <input type="checkbox"/> Missing

M2. Please describe:

Make	Model	Year of Manufacture
96. <input type="checkbox"/> Can't recall/don't know 97. <input type="checkbox"/> Prefer not to answer	96. <input type="checkbox"/> Can't recall/don't know 97. <input type="checkbox"/> Prefer not to answer	96. <input type="checkbox"/> Can't recall/don't know 97. <input type="checkbox"/> Prefer not to answer

M3. Do you know if this machine has any safety features? (ie. Guards, ROPS, seatbelt, safety switches, etc)

1. Yes (If **Yes**, please specify) 2. No ➔ If **No**, please go to **M4**.

96. <input type="checkbox"/> Can't recall/don't know	98. <input type="checkbox"/> Not applicable
97. <input type="checkbox"/> Prefer not to answer	99. <input type="checkbox"/> Missing



Features	Was this in use at the time of the injury?
Feature #1:	1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No
Feature #2:	1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No
Feature #3:	1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No
Feature #4:	1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No
Feature #5:	1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No
Feature #6:	1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No
Feature #7:	1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No

M4. Do you know how long this piece of machinery had been used on the farm prior to your injury?

_____ Years

- | | |
|--|---|
| 96. <input type="checkbox"/> Can't recall/don't know | 98. <input type="checkbox"/> Not applicable |
| 97. <input type="checkbox"/> Prefer not to answer | 99. <input type="checkbox"/> Missing |

M5. Do you know if this machine was purchased new?

1. Yes 2. No
(complete below)

- | | |
|--|---|
| 96. <input type="checkbox"/> Can't recall/don't know | 98. <input type="checkbox"/> Not applicable |
| 97. <input type="checkbox"/> Prefer not to answer | 99. <input type="checkbox"/> Missing |



If Not new, do you know where this machine was purchased?

1. Privately
2. Machinery dealer
3. Manufactured on your farm
4. Other (please specify) _____

M6. Do you know if there had been any modifications made to this piece of machinery prior to your injury?

1. Yes 2. No
↓ (If No, go to M7)

- | | |
|---|---|
| 96. <input type="checkbox"/> Can't recall/ don't know | 98. <input type="checkbox"/> Not applicable |
| 97. <input type="checkbox"/> Prefer not to answer | 99. <input type="checkbox"/> Missing |

If Yes, please describe what these were: _____

M7. Do you know when this machine was last serviced prior to your injury?

____ / ____ / ____
(Day Month Year)

- | | |
|--|---|
| 96. <input type="checkbox"/> Can't recall/don't know | 98. <input type="checkbox"/> Not applicable |
| 97. <input type="checkbox"/> Prefer not to answer | 99. <input type="checkbox"/> Missing |

M8. Do you know when the last major maintenance check of this machine was done prior to your injury?

____ / ____ / ____
(Day Month Year)

96. Can't recall/don't know

98. Not applicable

97. Prefer not to answer

99. Missing

M9. Do you know when this machine was last repaired prior to your injury?

____ / ____ / ____
(Day Month Year)

96. Can't recall/don't know

98. Not applicable

97. Prefer not to answer

99. Missing

M10. How would you describe the state of repair of this machine at the time of your injury?

1. Excellent

96. Can't recall/don't know

2. Above average

97. Prefer not to answer

3. Average

98. Not applicable

4. Below average

99. Missing

M11. What was your experience level with this machine prior to your injury?

1. <20 hours of operation

96. Can't recall/don't know

2. 20 to 100 hours of operation

97. Prefer not to answer

3. 100 to 200 hours of operation

98. Not applicable

4. > 200 hours of operation

99. Missing

M12. How long were you using this machine on the day of your injury?

_____ Hours

96. Can't recall/don't know

98. Not applicable

97. Prefer not to answer

99. Missing

M13. Do you have any other comments to make about the machinery involved?

M14. Is there any way that you think the machine could be made safer?

“Before I continue with the remainder of the interview, I will give you (send you) a survey regarding the type and amount of farm machinery which you operate in the course of a year on the farm. It is important that you complete this survey as soon as possible and return it to us in the reply paid envelope that is (will be) provided.”

C5. Had you taken any medications on the day of the injury? (Tick box)

1. Yes Go to C6

2. No Go to C7

96. Can't recall/don't know

98. Not applicable

97. Prefer not to answer

99. Missing

C6. What were those medications?

C7. What type of glasses were you wearing at the time of your injury?

1. No glasses

5. Multifocals

96. Can't recall/don't know

2. Reading glasses only

6. Contact lenses

97. Prefer not to answer

3. Long distance glasses

7. Sunglasses

98. Not applicable

4. Bifocals or trifocals

99. Missing

C8. Were you using any type of protective equipment at the time of the injury?

1. Yes Go to C9

96. Can't recall/don't know

98. Not applicable

2. No Go to C10

97. Prefer not to answer

99. Missing

C9. If yes, please specify. (Can select more than one category)

1. Ear muffs, plugs

6. Dust mask, respirator

2. Safety goggles

7. Disposable coveralls

3. Heavy gloves

8. Face shield

4. Heavy apron

9. Helmet (ATV, motorcycle)

5. Welding mask

10. Safety work boots

11. Other _____

96. Can't recall/don't know

98. Not applicable

97. Prefer not to answer

99. Missing

C10. Did you receive any first-aid treatment before getting to the hospital? (Tick box)

1. Yes (please specify)

2. No

96. Can't recall/don't know

97. Prefer not to answer

98. Not applicable

99. Missing

C11. How did you get to the hospital? (Tick box)

1. Ambulance

2. Drove self

3. Family/friend drove

4. Other _____

96. Can't recall/don't know

97. Prefer not to answer

98. Not applicable

99. Missing

C12. For how long were your normal working patterns disrupted (i.e., cannot work at the same pace or with the same ease as usual)? (Tick box)

1. A few hours

2. A few days

3. Week

4. Two weeks

5. Month

6. Still affected

7. Other (specify) _____

96. Can't recall/don't know

97. Prefer not to answer

98. Not applicable

99. Missing

C13. What were the costs associated with your injury to you and the farm enterprise?

a. Personal out-of-pocket costs associated with required treatment (eg. mileage to and from treatment centre, medications, etc.)

Estimated cost: \$ _____

“Now some questions about the **day before** the injury occurred.” (*Locate on calendar.*)

C14. How many hours did you work in the 24 hours prior to the day of the injury?

Farm work _____ hrs

- | | |
|--|---|
| 96. <input type="checkbox"/> Can't recall/don't know | 98. <input type="checkbox"/> Not applicable |
| 97. <input type="checkbox"/> Prefer not to answer | 99. <input type="checkbox"/> Missing |

C15. In the 24 hours prior to that day, do you know what proportion of your time was spent alone? (*Tick box*)

- | | |
|---|--|
| 1. <input type="checkbox"/> None | 5. <input type="checkbox"/> Three quarters |
| 2. <input type="checkbox"/> Almost none | 6. <input type="checkbox"/> Almost all |
| 3. <input type="checkbox"/> Quarter | 7. <input type="checkbox"/> All |
| 4. <input type="checkbox"/> Half | |

- | |
|--|
| 96. <input type="checkbox"/> Can't recall/don't know |
| 97. <input type="checkbox"/> Prefer not to answer |
| 98. <input type="checkbox"/> Not applicable |
| 99. <input type="checkbox"/> Missing |

C16. How many hours of sleep did you have in the 24 hours prior to the day of the injury?

Sleep _____ hrs

- | | |
|--|---|
| 96. <input type="checkbox"/> Can't recall/don't know | 98. <input type="checkbox"/> Not applicable |
| 97. <input type="checkbox"/> Prefer not to answer | 99. <input type="checkbox"/> Missing |

C17. Were you unwell in the 24 hours prior to the day of the injury (ie. flu, gastro, etc.)?

1. Yes (please specify)

2. No

- | |
|--|
| 96. <input type="checkbox"/> Can't recall/don't know |
| 97. <input type="checkbox"/> Prefer not to answer |
| 98. <input type="checkbox"/> Not applicable |
| 99. <input type="checkbox"/> Missing |

C18. During the 24 hours prior to your injury, had you used any herbicides or other pesticides? (*Tick box*)

1. Yes, please specify

2. No

- | |
|--|
| 96. <input type="checkbox"/> Can't recall/don't know |
| 97. <input type="checkbox"/> Prefer not to answer |
| 98. <input type="checkbox"/> Not applicable |
| 99. <input type="checkbox"/> Missing |

Now some questions about **the day, one week before** the injury occurred.

C20. Think about the day, one week before your injury, how many hours did you work in the 24 hour period prior to this day? (Locate on calendar).

Farm work _____ hrs

- | | |
|--|---|
| 96. <input type="checkbox"/> Can't recall/don't know | 98. <input type="checkbox"/> Not applicable |
| 97. <input type="checkbox"/> Prefer not to answer | 99. <input type="checkbox"/> Missing |

C20. Think about the day, one week before your injury. In the 24 hours prior to that day, what proportion of your time was spent alone? (Tick box)

- | | |
|---|--|
| 1. <input type="checkbox"/> None | 5. <input type="checkbox"/> Three quarters |
| 2. <input type="checkbox"/> Almost none | 6. <input type="checkbox"/> Almost all |
| 3. <input type="checkbox"/> Quarter | 7. <input type="checkbox"/> All |
| 4. <input type="checkbox"/> Half | |

- | |
|--|
| 96. <input type="checkbox"/> Can't recall/don't know |
| 97. <input type="checkbox"/> Prefer not to answer |
| 98. <input type="checkbox"/> Not applicable |
| 99. <input type="checkbox"/> Missing |

C21. Think about the day, one week before your injury. How many hours of sleep did you have in the 24 hours prior to that day?

Sleep _____ hrs

- | | |
|--|---|
| 96. <input type="checkbox"/> Can't recall/don't know | 98. <input type="checkbox"/> Not applicable |
| 97. <input type="checkbox"/> Prefer not to answer | 99. <input type="checkbox"/> Missing |

C22. Think about the day, one week before your injury. Were you unwell 24 hours prior to this day (ie. flu, gastro, etc.)?

1. Yes (please specify)

2. No

- | |
|--|
| 96. <input type="checkbox"/> Can't recall/don't know |
| 97. <input type="checkbox"/> Prefer not to answer |
| 98. <input type="checkbox"/> Not applicable |
| 99. <input type="checkbox"/> Missing |

C23. Think about the day, one week before your injury. During the 24 hours prior to this day, had you used any herbicides or other pesticides? (Tick box)

1. Yes, please specify

2. No

- | |
|--|
| 96. <input type="checkbox"/> Can't recall/don't know |
| 97. <input type="checkbox"/> Prefer not to answer |
| 98. <input type="checkbox"/> Not applicable |
| 99. <input type="checkbox"/> Missing |

C24. During the past 12 months what was the average number of hours per day you spent doing farm work? (This includes all activities connected with the farm enterprise, either on or off the farm.)

_____ Number of hours per day

- 96. Can't recall/don't know
- 97. Prefer not to answer
- 98. Not applicable
- 99. Missing

C25. During the past 12 months, on average, how many hours per week would you spend doing farm work?

_____ Number of hours per week

- 96. Can't recall/don't know
- 97. Prefer not to answer
- 98. Not applicable
- 99. Missing

If respondents report that their schedule varies during the year, prompt them as follows:

OK, let's talk about the different parts of the year. How many hours per week would you spend farming during....

Spring (September, October, November) _____ Number of hours per week

Summer (December, January, February) _____ Number of hours per week

Autumn (March, April, May) _____ Number of hours per week

Winter (June, July, August) _____ Number of hours per week

C26. For each of the situations described below, indicate whether you would seek medical treatment, and if so whether you would seek it from a local general practitioner (family doctor) or community nurse, or from the nearest hospital (emergency department).

Situation:	Medical treatment	Local GP (family doctor) or Community nurse	Nearest hospital (Emergency Department)
i. You injured your hand so that the skin on the palm of your hand was pulled off as if it was a glove...	1. <input type="checkbox"/> Yes → 2. <input type="checkbox"/> No	1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No	1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No
ii. You got a knock on your head, severe enough to make you unconscious for up to an hour...	1. <input type="checkbox"/> Yes → 2. <input type="checkbox"/> No	1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No	1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No

Situation:	Medical treatment	Local GP (family doctor) or Community nurse	Nearest hospital (Emergency Department)
iii. Your motor bike fell on you and you got bad bruising which meant you couldn't walk, and it was still too painful to walk the next day...	1. <input type="checkbox"/> Yes → 2. <input type="checkbox"/> No	1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No	1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No
iv. Something very heavy fell on your forearm resulting in an open wound through which you could see fragments of bone, and you were not able to move your arm properly...	1. <input type="checkbox"/> Yes → 2. <input type="checkbox"/> No	1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No	1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No
v. You cut your shin on a sharp edge of a piece of machinery. The cut did not appear to be deep and you were able to stop the bleeding fairly easily...	1. <input type="checkbox"/> Yes → 2. <input type="checkbox"/> No	1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No	1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No

C27. We may wish to undertake future studies on farm injury. Would you be willing to be contacted for future studies. The study would be explained at that time and you could accept or decline to participate.

1. Yes

2. No

96. Can't recall/don't know

98. Not applicable

97. Prefer not to answer

99. Missing

Interviewer:

“This is the end of the interview.

A copy of the findings will be available sometime in the year 2007. If you would like us to send you a copy please provide postal details. This information will be stored separately from the questionnaire and destroyed once the summaries are posted to individuals requesting them.”

Yes

No

Thank you very much for your cooperation.

ON COMPLETION

Please attach all completed forms and other related documents for this case to this questionnaire and return to MUARC in the reply paid envelope provided.

NB. If full consent form posted to case, ensure that a reply paid envelope is provided so that they are able to send the form directly to MUARC.

Checklist for materials to be sent to MUARC (tick box):

- Consent to be contacted (short) form**
- Verbal consent sign-off form**
- Questionnaire**
- Full consent form** **to be posted**
- Log book page for this case**