

Fall Risk Assessment

Resident Name: _____	Physician: _____
Room #: _____	Diagnoses: _____

Use this form as a guide to assess the resident's fall risk factors in the categories listed below through physical examination, observation and interaction with resident. For each category, place a check next to characteristic that best describes resident. The shaded characteristics indicate increasing levels of risk. The greater the number of checks belonging to that category, the greater risk of falls. Under evaluation describe how this category affects the resident. **Fall management applies for all residents, especially for those who:**

- Were recently admitted or have a change in rooms
- Have a change in physical/emotional status
- Were recently hospitalized
- Have experienced a recent fall

*** Any identified risk factor should be addressed on the care plan.**

Refer to "Restraints & Falls: Alternative Interventions" tool.

Key:

Low Risk	Moderate Risk	High Risk
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CATEGORY		CHARACTERISTIC	1	2	3	4	EVALUATION
MENTAL STATUS:	Level of Consciousness	Alert, oriented, or comatose					
		Knows own limits, reliable safety awareness					
		Diminished safety awareness					
		Poor recall and judgment					
MOBILITY:	Ambulatory Aid	Ambulatory without assistance					
		Bed rest/wheelchair/no assistance needed					
		Crutches/cane/walker needed					
		Furniture used for support					
		Wheelchair ambulation assistance needed					
	Gait	Normal walking/striding without hesitation					
		Weak walking and short, shuffled steps, lightly touching furniture for support					
		Impaired walking with difficulty rising from chair, head down, grasps furniture					
	Balance	Able to stand/walk, maintain body alignment					
		Balance problem while standing					
Balance problem while walking, stoop shoulders, able to lift head							
Balance problem while walking, stoop shoulders, unable to lift head							
Instability while turning							
Blood Pressure	NO noted drop between lying and standing						
	Drop LESS than 20 mm Hg between lying and standing						
	Drop MORE than 20 mm Hg between lying and standing						
External Applications	No external devices used (IV, heparin lock, feeding tube, cast/brace, foley catheter)						
	IV or heparin lock is present						
	Feeding tube is present						
	Casts/braces are present						
	Resident uses a foley catheter						

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MEDICAL STATUS/ HISTORY:	CATEGORY	CHARACTERISTIC	1	2	3	4	EVALUATION	
	Fall History	NO falls in past 3 months						
		1-2 falls in past 3 months						
		3 or more falls in past 3 months						
	Medications	<i>Respond below based on these medications: anesthetics, antihistamines, antihypertensives, antiseizures, benzodiazepines, cathartics, diuretics, hypoglycemics, narcotics, psychotropics, sedatives/ hypnotics</i>						
		Currently takes none of these medications						
		Currently takes 1-2 of these medications						
		Currently takes 3-4 of these medications						
	Continence Status	A change in medication and/or dosage in past 5 days						
		Ambulatory/continent						
Wheelchair or ambulatory aid/continent								
Ambulatory/incontinent								
Vision/Hearing	Wheelchair or ambulatory aid/incontinent							
	Adequate (with or without glasses/hearing aid)							
	Poor (with or without glasses/hearing aid)							
Predisposing Diseases/ Conditions	Legally Blind or very hard of hearing/deaf							
	<i>Respond below based on these conditions: hypotension, vertigo, CVA, Parkinson's, loss of limb(s), seizures, arthritis, osteoporosis, fractures, dementia, delirium, anemia, wandering, anger</i>							
	None present							
		1-2 present						
		3 or more present						

1.	Assessor Name: _____	2.	Assessor Name: _____
	Date: _____		Date: _____
3.	Assessor Name: _____	4.	Assessor Name: _____
	Date: _____		Date: _____

