

Fall Risk Assessment Form

Resident's Name:			Physician:				
Examiner →							
Assessment Date →							
PARAMETER	SCORE	RESIDENT STATUS/CONDITION	Enter Evaluation Score Below				
A.	Level of Consciousness/ Mental Status	0	ALERT (oriented X 3) OR COMATOSE				
		2	DISORIENTED X 3 at all times				
		4	INTERMITTENT CONFUSION				
B.	History of Falls (past 3 months)	0	NO FALLS in past 3 months				
		2	1 - 2 FALLS in past 3 months				
		4	3 OR MORE FALLS in past 3 months				
C.	Ambulation/ Elimination Status	0	AMBULATORY/CONTINENT				
		2	CHAIR BOUND - Requires restraints and assist with elimination				
		4	AMBULATORY/INCONTINENT				
D.	Vision Status	0	ADEQUATE (with or without glasses)				
		2	POOR (with or without glasses)				
		4	LEGALLY BLIND				
E.	Gait/Balance	To assess the resident's Gait/Balance, have him/her stand on both feet without holding onto anything; walk straight forward; walk through a doorway; and make a turn.					
		0	Gait/Balance normal				
		1	Balance problem while standing				
		1	Balance problem while walking				
		1	Decreased muscular coordination				
		1	Change in gait pattern when walking through doorway				
		1	Jerking or unstable when making turns				
		1	Requires use of assistive devices (i.e., cane, w/c, walker, furniture)				
F.	Systolic Blood Pressure	0	NO NOTED DROP between lying and standing				
		2	Drop LESS THAN 20 mm Hg between lying and standing				
		4	Drop MORE THAN 20 mm Hg between lying and standing				
G.	Medications	Respond below based on the following types of medications: Anesthetics, Antihistamines, Antihypertensives, Antiseizure, Benzodiazepines, Cathartics, Diuretics, Hypoglycemics, Narcotics, Psychotropics, Sedatives/Hypnotics.					
		0	NONE of these medications taken currently or within last 7 days				
		2	TAKES 1 - 2 of these medications currently and/or within last 7 days				
		4	TAKES 3 - 4 of these medications currently and/or within last 7 days				
		1	If resident has had a change in medications and/or change in dosage in the past 5 days = score 1 additional point				
H.	Predisposing Diseases	Respond below based on the following predisposing conditions: Hypotension, Vertigo, CVA, Parkinson's disease, Loss of limb(s), Seizures, Arthritis, Osteoporosis, Fractures.					
		0	NONE PRESENT				
		2	1 - 2 PRESENT				
		4	3 OR MORE PRESENT				
Total score of 10 or above represents HIGH RISK		TOTAL SCORE:					

(Name of Facility)

Fall Risk Assessment Form

If resident scored a 10 or above, interventions should be initiated. Document interventions below and on the resident's care plan. Resident should be informed of the risk/benefits associated with each intervention.

Intervention	By:	Date Initiated:	
Date Intervention Reviewed:	By:	Intervention effective? <input type="radio"/> Yes <input type="radio"/> No	
		Follow-up required? <input type="radio"/> Yes <input type="radio"/> No	
Comments:			
Intervention	By:	Date Initiated:	
Date Intervention Reviewed:	By:	Intervention effective? <input type="radio"/> Yes <input type="radio"/> No	
		Follow-up required? <input type="radio"/> Yes <input type="radio"/> No	
Comments:			
Intervention	By:	Date Initiated:	
Date Intervention Reviewed:	By:	Intervention effective? <input type="radio"/> Yes <input type="radio"/> No	
		Follow-up required? <input type="radio"/> Yes <input type="radio"/> No	
Comments:			
Date	Notes	Initials	
ID #	Room #	Resident Name:	Physician: