Ubiquity Quality Healthcare Group, Inc.

FALL RISK ASSESSMENT

Resident Name: _____ **Date:** _____

☐Admission ☐ Readmission ☐Change in Condition ☐Post-Fall ☐Quarterly

Circle appropriate score for each section and total score at bottom.

Parameter		Score	Patient Status/Condition
A.	Level of Consciousness/ Mental Status	0	Alert and oriented X3
		2	Disoriented X 3 at all times
		4	Intermittent confusion
B.	History of Falls (past 3 months)	0	No falls
		2	1-2 falls
		4	3 or more falls
C.	Ambulation/ Elimination Status	0	Ambulatory & continent
		2	Chair bound & requires assist w/ toileting
		4	Ambulatory & incontinent
D.	Vision Status	0	Adequate (w/ or w/o glasses)
		2	Poor (w/ or w/o glasses)
		4	Legally blind
E.	Gait and Balance	------	**Have resident stand on both feet w/o any type of assist then have walk: forward, thru a doorway, then make a turn**. (Mark all that apply.)
		0	Normal/safe gait and balance.
		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 assistance (person, furniture/walls or device).
F.	Orthostatic Changes **Take resident's blood pressure and pulse lying down, then again after standing up.**	0	No noted drop in blood pressure between lying and standing. No change to cardiac rhythm.
		2	Drop<20mmHg in BP between lying and standing. Increase of cardiac rhythm <20.
		4	Drop >20mmHg in BP between lying and standing. Increase of cardiac rhythm >20.
G.	Medications	------	**Based upon the following types of medications: anesthetics, antihistamines, cathartics, diuretics, antihypertensives, antiseizure, benzodiazepines, hypoglycemics, psychotropics, sedative/hypnotics.**
		0	None of these medications taken currently or w/in past 7 days.
		2	Takes 1-2 of these medications currently or w/in past 7 days.
		4	Takes 3-4 of these medications currently or w/in past 7 days.
		1	Mark additional point if patient has had a change in these medications or doses in past 5 days.
H.	Predisposing Diseases	------	**Based upon the following 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.
I.	Equipment Issues	O	No risk factors noted.
		1	Oxygen tubing.
		1	Inappropriate use of or resident does not consistently use assistive device.
		1	Equipment needs:
		1	Other:
TOTAL SCORE			**A score of 10 or more indicates <u>high risk for falls</u>. If score is 10 or more, complete page 2.**

Fall Risk Assessment Form

(Complete when Fall Risk score is 10 or greater.)

Fall Risk Interventions to be Employed:

1. _____
2. _____
3. _____
4. _____
5. _____

☐ Additional Services Requested:

☐ Skilled Nursing ☐ Physical Therapy ☐ Occupational Therapy ☐ Other: _____

Resident and/or responsible party has been informed about fall risk assessment results and safety/fall prevention recommendations:

☐ Yes ☐ No

Name of Responsible Party informed: _____

Has Physician been informed of the outcome of the Fall Risk Assessment? ☐ Yes ☐ No

Additional Comments:

_____

_____

_____

_____

_____

Signature of Staff Member Completing Assessment:

_____ Date: _____

Printed Name:

_____

Resident Name: _____