Fall Incident Assessment

Name:_____MR#:_____

Date of Fall: _____MD's Name: _____

Diagnosis: _____

Witness Fall? Yes _____No _____

Location of Fall: Bedroom _____ Bathroom _____ Den_____
Kitchen _____ Hallway _____ Stairs _____
Outside _____ Other: _____

Vital Signs: BP _____ T _____ P _____ R_____
Orthos: _____ Lying _____ Standing _____

Description of fall *(if applicable):*

_____ from bed: Side rails up_____ down_____

_____ getting in and out of bed

_____ from wheelchair

_____ ambulating: (___) assisted (___) unassisted

_____ tub, shower

_____ found on floor, wet floor (___) yes (___) no

_____ assistive devices (___) yes (___) no

_____ (___) wheelchair (___) walker (___) cane

_____ Environmental hazards identified?
described: _____
_____
_____

Patient's/PCG's account of the fall:_____
_____
_____
_____
_____

Patient's mental status prior to the fall (baseline): _____
_____
_____
_____

Patient's mental status at the time of fall ( ) alert ( ) disoriented ( ) confused
( ) sedated ( ) other _____

Was the patient experiencing any of the following at the time of the fall?

( ) Acute confusion

( ) Difficulty with ambulation

( ) Bowel or bladder urgency

( ) Emotional upset, anger, or agitation

( ) Medically unstable at time of fall

Previous fall ( ) yes ( ) no

Number during past six months: _____

Number resulting in injury: _____

Number of different medications patient has taken during the last 24 hours, including PRNs: _____

Medication categories:

( ) Cardiac meds

( ) Diuretic or antihypertensive

( ) Neuroleptic (sedative, hypnotic, antidepressive, psychotropic, antianxiety)

( ) Analgesic

( ) Laxative or stool softener

Patient fall risk factors: _____

_____

_____

_____

_____

What measures can be taken to prevent reoccurrence? _____

_____

_____

_____

_____

Post-injury care given:_____

_____

_____

_____

_____

Treatment plan: _____

_____

_____

_____

Was MD notified? No_____ Yes_____

Was the patient hospitalized? No_____ Yes_____

If yes, give details: _____

_____

_____

Signature: _____Date:_____

Source: Home Care of America, San Marino, CA.