

Patient:		Patient Age:	Clinician:	
Date of Fall:	Time of Fall:	Time Last Seen Prior to Fall:	Location of Fall:	
What was the patient doing at the time of the fall?				
Describe location where the fall occurred:			What was nurse/patient ratio at time of fall?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	1. Was this fall observed? If yes, by whom: _____			
<input type="checkbox"/> Yes <input type="checkbox"/> No	2. Was the patient alone at the time of the fall?			
<input type="checkbox"/> Yes <input type="checkbox"/> No	3. Was reason for fall evident? If yes, reason: _____			
<input type="checkbox"/> Yes <input type="checkbox"/> No	4. Did fall result in injury? If yes, injury _____			
<input type="checkbox"/> Yes <input type="checkbox"/> No	5. Did fall result in emergent care/hospitalization?			
<input type="checkbox"/> Yes <input type="checkbox"/> No	6. Does patient have/utilize any assistive device(s)? If yes, type: _____			
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	7. Was assistive device being used at time of fall?			
<input type="checkbox"/> Yes <input type="checkbox"/> No	8. Was therapy involved prior to fall? If yes, therapy included: _____			
<input type="checkbox"/> Yes <input type="checkbox"/> No	9. Was safety assessment documented prior to fall?			
<input type="checkbox"/> Yes <input type="checkbox"/> No	10. Was safety teaching documented prior to fall?			
<input type="checkbox"/> Yes <input type="checkbox"/> No	11. Were medications reviewed for fall potential?			
<input type="checkbox"/> Yes <input type="checkbox"/> No	12. Has the patient's health status changed?			
<b>Health Care Factors</b>				
<input type="checkbox"/> Yes <input type="checkbox"/> No	New/increase/decrease in blood pressure medication?	<input type="checkbox"/> Yes <input type="checkbox"/> No	New/increase/decrease in psychotropic medications?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	New/increase/decrease in pain medications?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Change in diagnosis status?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Changes in blood pressure?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Previous falls in past 6 months?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Recent return from hospital?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Decrease in fluid intake?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Recent weight loss?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Changes in mental status?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Recent fever/cough/cold?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Changes in behaviors?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Other: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	Changes in mobility status?	
<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	Other: _____	
<b>Environmental Factors</b>				
<input type="checkbox"/> Yes <input type="checkbox"/> No	Water spills?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Patient in a hurry? Why: _____	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Phone cords/TV cords on floor?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Patient not using cane/walker as instructed?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Clutter on floor?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Improper footwear?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Poor lighting?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Clothing got in the way?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Improper bed height?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Patient came tired?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Other furniture involved?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Patient reaching for items?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Wheelchair unlocked?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Patient using incontinent supplies at time of the fall?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Wheelchair foot rests in the way?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Other: _____	
<b>Analysis of Healthcare and Environmental Factors Contributing to the Fall</b>				
<input type="checkbox"/> Yes <input type="checkbox"/> No	Any unmet needs identified (i.e. re-education, environment, medications, therapy, etc.)?			
If yes, please explain: _____				
_____				