POST-FALL ASSESSMENT

Date of Assessment: __________ Date of Fall: __________ Time of Fall: __________ AM/PM

RN’s Section:

Date(s) of fall(s) within the past 30 days: ____________________________________________

Type of Fall: [ ] Witnessed Fall [ ] Un-witnessed Fall

Cause of Fall: ________________________________________________________________

Location of Fall: [ ] bedroom [ ] day hall [ ] bathroom [ ] out of doors [ ] other: ______

Activity at time of fall: [ ] resting/sleeping in room [ ] ambulating [ ] using bathroom [ ] engaged in activity: __________________________

If assistive devices needed, were they in use? [ ] N/A [ ] No [ ] Yes: [ ] walker [ ] cane [ ] wheelchair [ ] other: ______________________

If safety devices ordered, were they in use? [ ] N/A [ ] No [ ] Yes: [ ] bed alarm [ ] chair alarm [ ] door alarm [ ] hi/lo bed

Environmental Factors: [ ] wet floor [ ] crowded area [ ] visual blockage [ ] poor footwear [ ] lighting [ ] other: ______________________

Injury: [ ] No [ ] Yes: Nature of Injury: [ ] bruise/contusion [ ] abrasion [ ] Other: ______________________ Location: ______________________


Neuro Checks (if head injury suspected): Pupils: [ ] reactive [ ] non-reactive Hand Grasp: [ ] equal [ ] unequal

[ ] equal [ ] unequal Foot Strength: [ ] equal [ ] unequal

Notified: [ ] Attending Psychiatrist [ ] Ambulatory Care Services Clinician [ ] On-Call Physician

Date/Time: ______________________

RN Signature: ______________________ Print: ______________________ Date: __________ Time: ______ AM/PM

ACS Clinician/Attending Psychiatrist/On-Call Physician Section:

Was there a significant change in the patient’s psychiatric status in the week preceding the fall?

[ ] No [ ] Yes: Describe: ______________________

Was there a significant change in medical or neurological condition in the week preceding the fall?

[ ] No [ ] Yes - If yes, please specify (Check all that apply):

[ ] Infection [ ] New Medical Diagnosis [ ] Lethargy [ ] Unsteadiness
[ ] Visual Changes [ ] Auditory/Vestibular Changes [ ] Seizures [ ] Dialysis issues
[ ] Admission from Acute Care Hospital (within 3 days) [ ] Other: ______________________

Were there changes in prescribed medications preceding the fall?

[ ] No [ ] Yes: [ ] Refusal [ ] ↑ PRN Use [ ] Cardiac [ ] Psychotropic [ ] Other: ______________________

Describe: ______________________

ASSESSMENT: ______________________

PLAN: [ ] Physical Therapy Post Fall Assessment ordered and faxed to ext. 7012 (Required after all falls)

[ ] Ambulatory Care Services Referral [ ] Psychiatry Referral [ ] Occupational Therapy Referral
[ ] Pharmacy Consultation [ ] Medication Adjustment [ ] Review of Patient with Treatment Team
[ ] Level of Observation: ______________________ [ ] Other: ______________________

Complete Focused Treatment Plan Review? [ ] No – Not warranted at this time [ ] Yes – Complete Focused TPR (CVH-546)

Clinician Completing Assessment: [ ] Attending Psychiatrist [ ] Ambulatory Care Services Clinician [ ] On-Call Physician

Signature: ______________________ Print Name: ______________________ Date: __________ Time: ______ AM/PM

Consultation of the Medical Director is required for Frequent Falls –more than 2 falls within 30 days or Serious Fall - with injuries requiring medical intervention beyond first aid.

Medical Director Signature: ______________________ Print: ______________________ Date: ______ Time: ______ AM/PM

File Chronological with Progress Notes