Insert your logo here

Attach patient label here

Falls risk assessment

Item	Circle	COMMENTS
Patient input	Yes / No	
Family/Whānau input	Yes / No	
Carer input/other	Yes / No	
History of falls		**COMMENTS**
Frequency of falls		
Cause of fall *(slip, trip, fall, medical event)*		
Injuries from previous fall		
Fear of falling: Does the patient worry about falling or losing their balance?	Yes / No	
Consider: *Occupational therapy referral* *Physiotherapy referral*		
Mobility		**COMMENTS**
Unstable gait or looks unsafe walking	Yes / No	
Is this new for the patient?	Yes / No	
Does the patient use mobility aids?	Yes / No	
What mobility aids does the patient use?		
Consider: *Occupational therapy referral* *Physiotherapy referral*		
Vision, hearing, language		**COMMENTS**
Patient has hearing deficit	Yes / No	
Hearing aids are functional	Yes / No	
Consider: *Audiology referral*		
Patient has visual deficit	Yes / No	
Patient wears glasses?	Yes / No	
Consider: *Ophthalmology referral*		
Patient speaks and understands English?	Yes / No	
Consider: *Use of interpreter*		

Falls risk assessment

Cognitive assessment		COMMENTS
Patient has communication impairment?	Yes / No	
Patient has confusion/disorientation?	Yes / No	
Patient has memory loss?	Yes / No	
Patient is agitated, impulsive, or unpredictable?	Yes / No	
Patient overestimates/ forgets limitations?	Yes / No	
Patient has neurological condition?	Yes / No	
Consider: *Watch* *Medical review* *Written visual prompts* *Social work referral*		
Continence		**COMMENTS**
Patient has frequency, urgency or incontinence?	Yes / No	
Patient has a UTI?	Yes / No	
Consider: *Commode/bottle by bed* *Assessing for appropriateness of incontinence aids* *Referral to incontinence nurse*		
Medications		**COMMENTS**
Patient takes four or more drugs/day?	Yes / No	
Patient on psychotropic or sedative drugs?	Yes / No	
Patient on drug that may cause postural hypotension?	Yes / No	
Patient within 24-hr post-anaesthetic / sedation?	Yes / No	
Consider: *Pharmacy review* *Monitoring lying and standing BP* *Assistance with mobilisation*		
Other risks		**COMMENTS**
Does the patient have any other risk factors?	Yes / No	
Further comments and observations:		

Name of clinician who completed this falls risk assessment:

Name	Signature	Date