



Insert your logo here

Attach patient label here

Falls risk screening

Assessment input obtained from: _____ **Date:** _____

Patient
 Family/Whānau
 Carer
 Other _____

*

Falls risk screening

Falls screening	Yes	No	Comment
This patient is non- Māori or a Pacific Islander and is aged over 75 years			
This patient is Māori or a Pacific Islander and is aged over 55 years			
This patient has fallen or had a near miss (slipped, tripped or stumbled) in the past year			
This patient requires aids to mobilise			
My clinical judgement indicates a need to undertake the risk assessment			

If you indicated 'yes' to any of the above, please complete the falls risk assessment.

Health care professional:

Signature: _____ Name: _____

Designation: _____ Date: _____

