1.1 **IP-MORSE FALL ASSESSMENT** : The system shall allow the SN to input Morse Fall Risk Assessment Data

    i.   Date

    ii.   Time

    iii.   History of Falls(Yes / No) Yes =25, No=0

    iv.   Secondary Diagnosis (Yes / No) Yes=15. No = 0

    v.   Ambulatory Aid (Furniture / Crutches /Walker / Cane / None / Bed Rest/ wheel chair/ Nurse) Furniture = 30, Crutches/walker/cane = 15, others =0

    vi.   Heparin Lock (Yes /No) Yes =20, No =0

    vii.   Gait / Transferring (Impaired / Weak / Normal / Bed Rest / Immobile) Impaired = 20, weak=10, others =0

    viii.   Mental Status (Forgets Limitations / Oriented to Own ability) Forgets = 15, own =0

    ix.   Medication / Other condition (Under sedation or Anesthesia / None) Sedation =20 , None = 0

    x.   Physical Restraint (Yes / No) Yes =10/ No=0

    xi.   Fluid Restrictions (Yes / No) Yes=10, No=0

Based on the response, the score should be calculated and displayed in reports; Alert if the score is 45 or above

P.Id: 21CR-0123	NAVEEN YADAV IP - Bed # 21		Log out
CLINICAL CONDITION	DRUG ADMINISTRATION	CLINICAL INVESTIGATION	PAIN ASSESSMENT	M.MORSE FALL RISK	BRADEN ULCER RIS
NURSING CHECKLIST	NURSING GOALS	INTERDISCIPLINAR Y TEAM	FOOD & NUTRITION	PHYSIOTHERAPY	IN HOUSE PHARMAC
DOCTORS NOTES	HANDS OFF COMMUN	CRITICAL CONDITION CON	PATIENT EDUCATION	PATIENT DISCHARGE	ESCLATION & ALERT

MODIFIED MORSE FALL RISK ASSESSMENT

DATE [ ]   TIME [ ]   PAIN ASSESSMENT

SECONDARY DIAGONOSIS [▾]   AMBULATORY AID [▾]   HEPARIN LOCK [▾]

MENTAL STATUS [▾]   MEDICATION / OTHER [▾]   PHYSICAL RESTRAINT [▾]

FLUID RESTRAINT [▾]   SAVE   RESET

MODIFIED MORSE FALL RISK ASSESSMENT RECORDS

DATE	TIME	SECONDARY DIAGNOSIS SCORE	AMBULATORY AID SCORE	HERPARIN LOCK SCORE	MENTAL STATUS SCORE	SEDITATION SCORE	PHY RESTRAINT SCORE	FLUID RESTRAINT SCORE