POST FALL EVALUATION

Purpose: To encourage an effective evaluation of circumstances and conditions related to a recent fall in efforts to identify unmet risks.

Patient Name _____ **Fall Date** _____ **Clinician** _____

1. Was this fall observed? ☐ No ☐Yes, By Whom?_____
2. Location of fall. _____
3. Was the patient alone during the fall? ☐ Yes ☐ No
4. What was the patient doing during the fall?_____
5. Was this the patients first fall? ☐ Yes ☐ No
6. Were protective or safety devices in use at time of fall? ☐ No ☐ Yes,
   If yes describe devices._____
7. Describe the location where the fall occurred:

Clue	Yes	No	Clue	Yes	No
Water Spills			Patient in a hurry? (why)		
Phone/TV cords on floor			Patient not using cane/walker as instructed		
Clutter on the floor			Improper footwear		
Poor lighting			Clothing got in the way		
Improper bed height			Patient became tired		
Other furniture involved			Patient reaching for items		
Wheelchair unlocked			Patient using incontinent supplies at time of fall?		
Wheelchair foot rests in the way			Other:		

8. Has the patient's health care status changed?

Clue	Yes	No	Clue	Yes	No
New/Increased/decrease in blood pressure medications.			Decrease in fluid intake		
New/Increased/decrease in blood Psychotropic medications			Recent fever/cough/cold		
New/Increased/decrease in pain medications.			Change in diagnosis status		
Change in blood pressure			Change in mental status		
Recent return from Hospital			Change in Behaviors		
Recent weight loss			Change in mobility status		
Other					

Analysis:
Do the clues reflect environmental factors that could have contributed to the fall? ☐No ☐Yes,
Do the clues reflect any health factors that could have contributed to the fall? ☐No ☐ Yes,
Are there similarities to the previous fall? ☐ No ☐ Yes,
Any unmet needs identified (i.e. reeducation, environmental, medications, Etc.) ☐ No ☐ Yes