FALL RISK SCREENING, ASSESSMENT AND PLAN OF CARE

This form is for ALL patients 65 years & older with Initial Evaluation & Billable Re-evaluation

Patient Name:_____ Account #: _____ Date:_____

FALL RISK SCREENING

THE THREE "KEY" QUESTIONS	*or*	"CHECK YOUR RISK FOR FALLING" CHECKLIST
1. Have you fallen in the past year? ☐ Yes ☐ No If yes, how many times? _____ Did any fall result in an injury? ☐ Yes ☐ No 2. Do you feel unsteady when standing or walking? ☐ Yes ☐ No 3. Do you worry about falling? ☐ Yes ☐ No		☐ Check if patient completed the questionnaire and include the complete form in the medical record
If patient answers **"Yes" to any** of these 3 questions or any fall resulted in an Injury, the Patient is AT RISK FOR FALLS and requires a Falls Plan of Care.		If patient scores **≥4** on the Checklist, the Patient is AT RISK FOR FALLS and requires a Falls Plan of Care.

RISK FACTORS

Check all that apply:

☐ Vision impairment	☐ Vitamin D insufficiency	☐ Gait & Balance Disorders	☐ Post-Operative Status
☐ Medications linked to falls	☐ Postural hypotension	☐ Arthritis or Osteoporosis	☐ Diabetes
☐ Parkinson's Disease	☐ Cognitive Impairments	☐ Incontinence	☐ Neurological Impairments
☐ Other: _____		☐ Home hazards:_____	

FALL RISK ASSESSMENT PERFORMED

Check the Fall Assessment Test(s) Performed:

☐ Timed Up & Go (TUG)	☐ 30-Second Chair Stand	☐ Berg Balance Test
☐ The 4-Stage Balance Test	☐ Tinetti Gait & Balance Test	☐ Dynamic Gait Index
☐ Other: _____		

*********Include the completed Fall Assessment Test/Outcome/Score in the Medical Record*********

PLAN OF CARE FOR FALL RISK PATIENTS

PLAN OF CARE: REQUIRED if patient is "At Risk" for fall (2 or more falls OR any fall with injury in the past year). POC also suggested if patient exhibits any other risks for falls or by the clinical judgment of the supervising therapist.

Documentation in the Evaluation & Plan of Care should include the following for fall prevention:

- Balance, strength and gait training
- Patient advised to ask physician about Vitamin D supplementation
- Consideration of assistive devices
- Include GOALS in your Plan of Care for Fall Prevention, such as, patient will participate in skilled physical therapy to include LE strengthening program, dynamic balance training, and gait training with appropriate assistive device on level surfaces, stairs, and environmental surfaces.

_____ _____ _____

Therapist Signature **Therapist Name (Printed), Credentials** **Date**