

## Falls Risk Screening and Action Plan Tool

**Yes responses indicate risk and the need to initiate action. Name**

**Choose the most appropriate action.**

**DOB**

**Gender:**

**UR No:**

<b>1.Falls History</b>	<b>Yes</b>	<b>No</b>	<b>Action Plan</b>
No. of falls in last 6 months  Details of last fall..... .....  Does fear of falling stop you from engaging in some activities?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Referral to GP <input type="checkbox"/> Referral to physiotherapist <input type="checkbox"/> Referral to occupational therapist <input type="checkbox"/> Referral to falls and balance clinic <input type="checkbox"/> Consider personal alarm <input type="checkbox"/> Other, please specify  Comment.....
<b>2. Medical</b>			
Has it been more than a year since your last GP visit?  Presence of a chronic condition eg. Diabetes, CHF, COAD, Arthritis  Are you presently unwell?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Referral to GP <input type="checkbox"/> Referral to physiotherapist <input type="checkbox"/> Other, please specify
<b>3.Medications</b>			
Are you taking 4 or more medications?  Has it been more than 12 months since your GP reviewed your medications?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Referral to GP <input type="checkbox"/> Referral to pharmacist <input type="checkbox"/> Other, please specify
<b>4. Mobility and Balance</b>			
Does the client appear unsteady on feet?  Does client require assistance getting out of chair?  Does client use a walking aid?  Does client have difficulty using stairs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Referral to physiotherapist <input type="checkbox"/> Referral to occupational therapist <input type="checkbox"/> Other, please specify
<b>5 Mental/Cognitive Status</b>			
Does client appear confused?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Referral to GP <input type="checkbox"/> Referral to ACAS <input type="checkbox"/> Other, please specify
<b>6. Vision</b>			
Has it been more than 12 months since your last vision check?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Referral to GP <input type="checkbox"/> Referral to optometrist <input type="checkbox"/> Other, please specify

<b>7. Home Environment</b>			
Have you had any falls at home?	<input type="checkbox"/>	<input type="checkbox"/>	
Potential risk at home such as rugs, frayed carpet, clutter?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Referral to occupational therapist <input type="checkbox"/> Other, please specify
Do you have any rails installed?	<input type="checkbox"/>	<input type="checkbox"/>	
<ul style="list-style-type: none"> <li>• Kitchen</li> <li>• Bathroom</li> <li>• Toilet</li> <li>• Front Door</li> </ul>			
<b>8. Foot conditions/pain</b>			
Do you have any foot pain?	<input type="checkbox"/>	<input type="checkbox"/>	
Does client have bunions, corns, swelling?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Referral to podiatrist <input type="checkbox"/> Referral to GP <input type="checkbox"/> Other, please specify
Do you wear slippers, scuffs, thongs or high heel shoes?	<input type="checkbox"/>	<input type="checkbox"/>	
<b>9. Nutrition</b>			
Have you experienced any unintentional weight changes? That is a weight gain or weight loss of over 5kgs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Referral to dietician <input type="checkbox"/> Referral to GP <input type="checkbox"/> Other, please specify
Have you recently experienced changes to your eating? That is, loss of appetite or overeating.	<input type="checkbox"/>	<input type="checkbox"/>	
<b>10. Continence</b>			
Do you have continence issues?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Referral to continence clinic <input type="checkbox"/> Referral to RDNS continence nurse <input type="checkbox"/> Referral to occupational therapist for commode use/other functional aids <input type="checkbox"/> Other, please specify

**If client presents with multiple risk factors, consider referral to a specialist clinic listed in the local Falls Prevention Services Directory.**

What other health/community services are you receiving? E.g. CACPS, community rehabilitation, home help, district nursing, personal care.....

Do you have a case manager? Y/N

Name.....Ph. No.....

**Has the client been issued with a Falls Prevention Education Kit? Y/N**

**Additional comments:** .....

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**Date.....Assessor.....Position .....**