FALL RISK ASSESSMENT TOOL

Directions: Place a check mark in the box of column labeled yes if the risk factor applies to your patient. A patient with a check mark in the box for a risk factor with an asterisk (*) or four or more other risk factors would be considered at risk for falls.

Risk Factor	Yes
Confusion/Disorientation*	
Age over 60	
Dizziness/Imbalance	
Unsteady gait, perform "Get-Up-and-Go Test" if needed	
Problems/disease affecting weight-bearing joints	
Weakness	
Seizure Disorder	
Impairment of vision and/or hearing	
Altered elimination (bowel and/or bladder)	
Impaired Memory/Judgment/Impulsivity	
Inability to understand or follow directions	
Use of diuretics or drugs with diuretic effects	
Hypotensive	
Use of CNS suppressants (e.g., narcotic, sedative, psychotropic, hypnotic, tranquilizer, antihypertensive, antidepressant)	
Use of Ambulatory Devices (cane, crutches, walker, wheelchair, braces, geriatric (geri) chair	
History of two or more falls within last 12 months*	
History of one or more falls within last 12 months resulting in moderate or worse injury*	

An injury is defined in the terms listed below:

1. *None* indicates that the patient did not sustain an injury secondary to the fall.
2. *Minor* indicates those injuries requiring a simple intervention.
3. *Moderate* indicates injuries requiring sutures or splints.
4. *Major* injuries are those that require surgery, casting, further examination (e.g., for a neurological injury).
5. *Deaths* refers to those that result from injuries sustained from the fall.

TIMED GET UP AND GO TEST

This test is performed with patient wearing regular footwear, using usual walking aid if needed, and sitting back in a chair with arm rest. On the word, "Go", the patient is asked to do the following:

1. Stand up from the arm chair
2. Walk 10 feet in a line
3. Turn
4. Walk back to chair
5. Sit down

Repeat the test and time the second effort. Observe patient for postural stability, gait, stride length and sway.

Scoring: Normal: completes task in < 10 seconds
Abnormal: completes task in >20 seconds

Low scores correlate with good functional independence; high scores correlate with poor functional independence and higher risk of falls.

NOTE: IF the patient is at risk for a fall based on one or both of these test, a follow up plan for safety needs to be documented in the treatment plan.

Sources: www.NBCI.gov; Hendrich II Fall Risk Model; Brians LK Risk tool for fall prevention