Fall Report Form

INFORMATION ABOUT INDIVIDUAL INVOLVED IN THE FALL	
Name:	**Consumer #:**

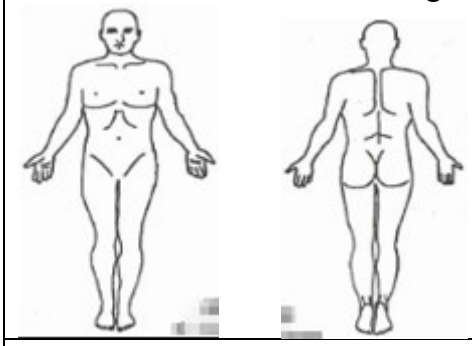
INFORMATION ABOUT THE FALL	
Date of Fall:	**Time:** ☐ AM ☐ PM

Location of Incident
☐ Outdoors (specify)_____
☐ Community (specify)_____
☐ Home: (specify which room**)**_____

Were There Any Witnesses to the Incident? ☐ Yes ☐ No

Names of Witness(es):

If witnessed, mark on the diagram which body part hit the ground or a stationary object:



Surface Type (check all that are applicable):
☐ Carpet ☐ Linoleum ☐ Tile ☐ Wood ☐ Grass ☐ Gravel ☐ Concrete
☐ Other (specify):

Surface Conditions (check all that are applicable):
☐ Wet ☐ Damaged ☐ Slippery ☐ Icy ☐ Dry ☐ Level ☐ Uneven ☐ Other (specify):

Complete Only for Injuries Related to Falling Out of Bed:
What was the position of the bed? ☐ High ☐ Low ☐ Head raised ☐Foot raised ☐ Other (specify):

Was the Individual Wearing Shoes? ☐ Yes ☐ No
What type of shoes was the individual wearing? ☐ Sandals ☐ Tennis Shoes ☐ Slip-ons ☐ Dress Shoes ☐ Boots
☐ **Other:**_____
Did the individual have: ☐ Regular Socks ☐ Grip Socks ☐ Bare feet

Number of Falls Within the Past 30 Days?

Does the Individual Remember the Fall? ☐ Yes ☐ No ☐ N/A
If the individual did not remember the fall, did they lose consciousness? ☐ Yes ☐ No ☐ N/A
If they did, or they can't remember, is it possible they sustained a head injury? ☐ Yes ☐ No ☐ N/A
Was it necessary to seek emergency medical attention: ☐ Yes ☐ No ☐ N/A

(if emergency medical attention was sought please ensure discharge papers are included in with Incident Report)
Was the Individual's Primary Care Physician (PCP) Notified? ☐ Yes Date: _____ Time: _____ **What was the PCP response?** ☐ No – **state rationale for not contacting the PCP:**
Does the Individual Use Assistive Technology (Walker, quad cane, wheelchair, gait belt, bed alarms)? ☐ No ☐ Yes, **please identify the Assistive Technology:**_____ **Did this contribute to the fall:**
Was the Individual's psychiatrist notified? ☐ Yes ☐ No
Does the individual have Occupational Therapy services? ☐ Yes ☐ No
Does the individual have Registered Nursing services? ☐ Yes ☐ No If yes, **what was the fall risk score:**_____ **Date of last completion:**_____
PRESCRIBED MEDICATIONS
Is the individual taking any Blood Pressure Medications? ☐ Yes ☐ No
If yes, what was most recent blood pressure reading? _____ **Date of last completion:**_____
Is the individual taking any diabetic medications? ☐ Yes ☐ No
If yes, what was most recent blood glucose reading? _____ **Date of last completion:**_____
Have there been any changes in medication/medication dose over the past two weeks? ☐ Yes ☐ No
<u>If yes, please list the change(s).</u>
Are any of the prescribed medications for pain? ☐ Yes ☐ No
Did medications contribute to fall? ☐ Yes ☐ No
If dedicated staff, has the PCP and Psychiatrist been informed of medication interactions? ☐ Yes - **add to fall risk** ☐ No
ADDITIONAL INFORMATION
REPORTER INFORMATION
Individual Submitting the Report (print name):
Signature:
Date Report Completed: