Falls assessment

HISTORY OF INDEX FALL 1st fall? YES / NO .

Date of fall		Time of day		Location		Inside/outside	
Memory of fall?	Yes / No	Dizziness?	Yes / No	Palpitations?	Yes / No	LOC?	Yes / No
Activity at time of fall / explanation of fall							

Number of other falls in previous year? ☐ Please give details: _____

_____

_____

Falls Risk Factors – please tick all that apply:

Orthostatic Hypertension		Syncope		Gait/balance probs Stroke/ PD etc..		Environment / footwear		Impaired Cognition/ depression	
Hearing Impairment		Polypharmacy [4or more meds]		Joint Disease		Visual Impairment		Other – (Specify)	

Culprit medications [pls list] : _____

_____

Cause of fall	Unexplained		Slip / trip / environmental		Syncope/ collapse?cause		Multifactorial

1	Staying steady [age concern] leaflet	
2	Healthy bones [age concern] leaflet	

Follow up

Rehab.@ ……..		Community Physio		Podiatry	
……..Day Hospital for medical rv &/or falls assessment		Other specialty [specify]		Audiology	
DXA scan [form sent]					

…… = Consultant / SpR / Staff Grade Date ……
[Physician in Medicine for Older People]