

Community-based Fall Risk Education and Assessment

Patient Form

Name: _____

Address/postal code: _____

Home Phone: _____

Screening Results:

Timed-Up-And-Go Test Score: _____ (>14 seconds indicates increased fall risk)

Elderly Falls Screening Test Score: _____ (≥ 2 indicates increased fall risk)

Risk Identification:

Low - maintains healthy habits Moderate - benefit from lifestyle modification, selected referrals High - risk factors to be addressed by health care team

Relevant risk factors for falls:

- | | |
|----------------------------------------------------------|--------------------------------------------------------|
| <input type="checkbox"/> Previous falls or near falls | <input type="checkbox"/> Gait/mobility risk |
| <input type="checkbox"/> Previous fractures/Osteoporosis | <input type="checkbox"/> Endurance/weakness |
| <input type="checkbox"/> Sensory risk | <input type="checkbox"/> Dizziness or balance problems |
| <input type="checkbox"/> > 4 Medication risk | <input type="checkbox"/> Arthritis/pain |
| <input type="checkbox"/> > 1 Drink of alcohol/day | <input type="checkbox"/> Inadequate nutrition |
| <input type="checkbox"/> Medical risk | <input type="checkbox"/> Incontinence |
| <input type="checkbox"/> Cognitive risk | <input type="checkbox"/> Sleeping problems |
| <input type="checkbox"/> Environmental hazards | <input type="checkbox"/> Depression or Anxiety |

Recommendations for Risk Factor Modification:

- Discuss the findings of this screening with your physician
- Discuss your medication risk with your pharmacist and/or physician
- See your optometrist for an eye exam
- Seek foot care services from a podiatrist or foot care nurse
- Participate in exercises to improve leg strength and balance
- Carry out a home safety checklist and make changes you identify to decrease your risk

Comments: _____

Screened by (name/title): _____ Date: _____

Telephone: _____

