



Fall Risk Assessment

Patient Name: _____

Date Completed _____

Patient Factors	Score
History of falls (any in the past 3 months?)	15
Sensory Deficit (vision and/or hearing)	5
Age (over 65)	5
Confusion	5
Impaired judgement	5
Decreased level of cooperation	5
Increased anxiety/emotional liability	5
Unable to ambulate independently (needs to use ambulatory aide)	5
Gait/balance/coordination problems	5
Incontinence/urgency	5
Cardiovascular/respiratory disease affecting perfusion and/or oxygenation	5
Postural hypotension with dizziness	5
Medications affecting blood pressure or level of consciousness (consider Antihistamines, antihypertensives, antiseizure, benzodiazepines, cathartics, Diuretics, hypoglycemics, narcotics, psychotropics, sedatives/hypnotics)	5
Alcohol usage	5
Home safety issues (lighting, pathway, cord, tubing, floor coverings, stairs, etc.)	5
Lack of home modifications (bathroom, kitchen, stairs, entries, etc.)	5

Total Points: _____

Circle the point values for any of the applicable questions. Total the score and enter on the space provided above.

Implement fall precaution for a total score of 15 or greater

1. Educate on fall prevention strategies specific to areas of risk
2. Refer to Physical Therapy and or Occupational Therapy
3. Monitor areas of risk to reduce falls
4. Reassess patient

Nurse Signature: _____

Date: _____

SKILLED NURSING VISIT NOTE

DATE OF VISIT _____
 TIME IN _____ OUT _____

HOMEBOUND REASON: Needs assistance for all activities Residual weakness Requires assistance to ambulate
 Confusion, unable to go out of home alone Unable to safely leave home unassisted
 Severe SOB, SOB upon exertion Dependent upon adaptive device(s) Medical restrictions
 Other (specify) _____

TYPE OF VISIT: SN SN & Supervisory
 Supervisory Only Other

NURSING DIAGNOSIS/PROBLEM _____

VITALS

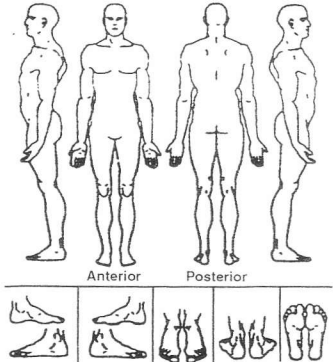
T° _____ Wt. _____
 Resp. _____ Reg. Irreg.
 Pulse: A _____ R _____
 Regular Irregular

NURSING ASSESSMENT AND OBSERVATION SIGNS/SYMPTOMS (Mark all applicable with an "X". Circle appropriate item(s) separated by "/".)

CARDIOVASCULAR	GENITOURINARY	MUSCULOSKELETAL
Fluid retention	Burning	Balance/Unsteady gait
Chest pain	Distension/Retention	Weakness
Neck vein distension	Frequency/Urgency	Other: _____
Edema (specify)- <input type="checkbox"/> RUE <input type="checkbox"/> LUE <input type="checkbox"/> RLE <input type="checkbox"/> LLE	Hesitancy	NEUROSENSORY
Peripheral pulses	Hematuria	Syncope
Other: _____	Bladder incontinence	Headache
	Catheter	Grasp- Right: _____ Left: _____
	Urine- Color: _____ Consistency: _____ Odor: _____	Movement <input type="checkbox"/> RUE <input type="checkbox"/> LUE <input type="checkbox"/> RLE <input type="checkbox"/> LLE
RESPIRATORY		Pupil reaction- Right: _____ Left: _____
Rales/Rhonchi/Wheeze	Pain	Tremors
Cough	Discharge	Vertigo
Dyspnea/SOB	Diabetic urine testing	Speech impairment
Orthopnea	Other: _____	Hearing impairment
Other: _____	SKIN	Visual impairment
	Color: _____	Decreased sensitivity
DIGESTIVE	Jaundiced	Other: _____
Bowel sounds	Temperature	EMOTIONAL STATUS
Nausea/Vomiting	Chills	Disoriented
Anorexia	Decubitus/Wound	Lethargic
Epigastric distress	Rash/Itching	Agitated
Difficulty swallowing	Turgor	Oriented
Abdominal distension	Other: _____	Comatose
Colostomy	PAIN	Depressed
Diarrhea	Origin: _____	Other: _____
Constipation/Impaction	Location: _____	
Bowel incontinence	Duration: _____	
Other: _____	Intensity: (0-10): _____	
	Other: _____	

B/P	LYING	SITTING	STANDING
Right			
Left			

Denote Location / Size of Wounds / Pressure Sores / Measure Ext. Edema Bil.



	#1	#2	#3	#4
Length				
Width				
Depth				
Drainage				
Tunneling				
Odor				
Sur. Tis.				
Edema				
Stoma				

INTERVENTIONS/INSTRUCTIONS (Mark all applicable with an "X". Circle appropriate item(s) separated by "/".)

Skilled observation & assessment	Chest physio./Postural drainage	IM injection	Evaluate diet/fluid intake
Foley care	Change NG/G tube	Psych. intervention	Diet teaching
Urine testing	Admin. of vitamin B12	Observe S/S infection	Safety factors
Wound care/dressing	Prep./Admin. insulin	Diabetic observation	Prenatal assessment
Decubitus care	Teach/Admin. IVs/Clysis	Teach diabetic care	Post-partum assessment
Venipuncture	Teach ostomy/ileo. conduit care	Observe/Teach medication (N or C) effects/side effects	Teach infant/child care
Post-cataract care	Teach/Admin. tube feedings	Physiology/Disease process teaching	Pain Management
Bowel/Bladder training	Teach/Admin. care of trach.	Observe ADLs	Other: _____
Digital exam with manual removal/Enema	Teach/Admin. Inhalation Rx		
	Teach care - terminally ill		

ANALYSIS/INTERVENTIONS/INSTRUCTIONS/PATIENT RESPONSE _____

CARE PLAN: Reviewed/Revised with patient involvement
 Outcome achieved PRN order obtained
PLAN FOR NEXT VISIT
 APPROXIMATE NEXT VISIT DATE ____/____/____
 MEDICATION STATUS: No change Order obtained
 DISCHARGE PLANNING DISCUSSED? Yes No N/A
 BILLABLE SUPPLIES RECORDED? Yes No
 CARE COORDINATION: Physician PT OT ST SS
 SN Other (specify) _____

AIDE SUPERVISORY VISIT (Complete if applicable.)
 AIDE: Present Not present
 SUPERVISORY VISIT: Scheduled Unscheduled
 AIDE CARE PLAN UPDATED? Yes No
 OBSERVATION OF _____
 TEACHING/TRAINING OF _____
 NEXT SCHEDULED SUPERVISORY VISIT ____/____/____

SIGNATURE/DATE—Complete TIME OUT (above) prior to signing below.
 X _____ / ____ / ____
 Nurse (signature/title) _____ Date _____
 Patient Signature (optional) _____

PART 1 - Clinical Record

PART 2 - Care Coordination

PATIENT NAME - Last, First, Middle Initial _____ ID# _____

