Fall Prevention Assessment

Date of fall:
UCI # (Vendor to Complete):
SANDIS Incident # (RC to Complete):

Individual's Age: ☐ 0-18 ☐ 19-25 ☐ 26-40 ☐ 41-55 ☐ 55 and over
How did the fall happen?
How can future falls be avoided?

Where did the fall occur? (check all boxes that apply)

☐ Home	☐ Day Program	☐ Work	☐ Community Setting	☐ Living Room
☐ Bedroom	☐ Bathroom	☐ Kitchen	☐ Dining Room	☐ Family Room
☐ Yard/Patio	☐ Park	☐ Restaurant	☐ Retail/Shopping	☐ Library
☐ Parking Lot	☐ Sidewalk	☐ Location of the fall was new or unfamiliar to the individual		
☐ Other:				

Did medical issues contribute to the fall?
(If Yes, check all that apply)
☐ Assistance walking device was in use when they fell: ☐ Walker ☐ Cane ☐ Wheelchair ☐Gait belt
☐ Individual was experiencing changes in: ☐ Vision ☐ Hearing ☐ Gait ☐ Health
☐ Recent medical changes ☐ Recent medical diagnosis ☐ Seizure Disorder
☐ Other:

Fall prevention happens in steps:

STEP 1: Identify and eliminate/reduce fall hazards
STEP 2: Identify changes in the individual's health status and alert ALL staff
STEP 3: Create new plan for the individual
STEP 4: Continuously reassess steps 1-3; adjust as needed

STEP 1: Identify and eliminate/reduce fall hazards (check all that apply)
☐ Carpeting/rugs not properly secured to the floor or lying flat
☐ Change in flooring/threshold
☐ Transferring from one position to another
☐ No handrails/grab bars available
☐ Rubber bathtub mats not in place
☐ Insufficient light, too dim, and/or no nightlight present
☐ Missing, defective, or improperly used assistive device
☐ Failure of individual/staff to follow protocols for assistance (transfers)
☐ Distracted caregiver/individual
☐ Shoes, clothing, pets, children, or other obstacles blocking the path
☐ Physical walking distance of destination too far
☐ Wet, icy, uneven, or rocky terrain, construction, crowds, or other hazards
☐ Individual in a rush/not paying attention
☐ Staff assisting distracted
☐ Inappropriate footwear: ☐ Wrong size (too big/small) ☐ Shoelaces untied ☐ Wrong shoe type for environment
☐ Other:

STEP 2: Identify changes in the individual's health status and alert ALL staff (check all that apply)

☐ Individual dizzy/disoriented due to new, changed, or missed medication
☐ Individual experienced loss of leg strength or change in gait due to change in health/diagnosis
☐ Individual experienced shortness of breath
☐ Individual experienced confusion related to use of new mobility device(s)
☐ Individual's behaviors and/or mental health may have contributed to the fall
☐ Individual experienced seizure activity
☐ Individual has experienced at least one fall in the past six months
☐ Individual displayed any pain or discomfort prior to the fall
☐ Other:

STEP 3: Create a plan to avoid falls, make appropriate environmental changes, train staff on the work plan, and look for additional fall risks. If a Behavior Plan is needed, please attach a completed copy to this form.
Please address all checked boxes and attach extra pages as needed.

STEP 4: Continuously reassess current plan and make necessary changes. This plan is a living document and should be discussed with the Service Coordinator at every meeting. The plan is designed to reduce falls through an increased focus on strategies of fall prevention.

Is assistance requested from the Regional Center to complete the fall plan?
If Yes, please describe:

Signature of Service Provider **Name of Facility** **Date**

Regional Center Use Only **Date of Incident:**
Injury as a result of incident:
Approved or denied by Community Service Committee Date:
Notes: