COLUMBUS COMMUNITY HOSPITAL

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Orthopedics

FALL RISK ASSESSMENT (AGE 65 AND OLDER)

(NOTE: This screening is required by the federal mandate to be completed annually)

Patient Name: ________________________________

Date of Birth: _________________________________

Today's Date: _________________________________

<u>Increased Fall Risk Factors (check each that applies)</u>

____________Diagnosis (do you have 3 or more medical issues?)

___________Do you have a history of falls within the past three months?

___________Incontinence or uncontrolled bladder?

___________Visual Impairment (do you have trouble seeing?)

___________Impaired functional mobility (do you use a cane or walker?)

___________Polypharmacy (do you take more than 3 medications?)

___________Does pain keep you from performing daily activities?

___________ None of the above

History of a fall in the past 12 months YES NO

If yes, were you injured? YES NO

How many falls in the past year? _________