FALL INCIDENT REPORT
(This tool is only an example. Please adapt it to meet the needs of your facility and residents.)

MR # __________ Last Name ________________________ First Name ______________ Room # ______

Date ______________ Time _____________ am/pm □ Resident □ Employee □ Visitor

Type of Incident (Check): □ Fall □ Behavior □ Other (Specify):

______________________________________________________________________________________
______________________________________________________________________________________

Physical Assessment:
If fall what position was person found in? (Describe in detail): ____________________________________

______________________________________________________________________________________

Describe mobility or range-of-motion of extremities following incident: ________________________________

______________________________________________________________________________________

Is assessed mobility or range-of-motion ability a change? (Check): □ No □ Yes (Describe): ________

______________________________________________________________________________________

Injury (Check): □ None □ Laceration □ Skin Tear □ Abrasion □ Hematoma □ Swelling □ Other
(Describe and Locate on Diagram): __________________________________________________________

Vital Signs: Other:
B/P Lie Temp _________ BG Accu Check ______
B/P Sit Pulse _________ Pulse Oximetry ________
B/P Stand Resp ________ Neuro Checks ________

Treatment (Check All That Apply)
□ Examined at Hospital: ________________________ □ Admitted to Hospital: ______________________
□ Xray Done (Results): _________________________ □ First Aid Administered: ______________________

______________________________________________________________________________________

Name of Person(s) Administering Treatment: _________________________________________________

______________________________________________________________________________________

Physician Notified: _________________ Time: _____ am/pm Response Time: _____ am/pm

Family/Other Notified: _________________ Time: _____ am/pm Response Time: _____ am/pm

(Complete Reverse at the Time of Incident)
Investigation

Exact Location of Incident (Check):  □ Resident’s Room  □ Hallway  □ Bathroom  □ Nursing Station  
□ Lobby  □ Shower Room  □ Dining Room  □ Other (Specify room #: hallway, bathroom, shower etc.)

□ Incident Witnessed  Name of Witness: ____________________________________________________
Address of Witness: __________________________________________________________________

□ Incident Un-Witnessed  Name of Person Who Discovered Incident: _______________________

Description of Incident:  _________________________________________________________________
____________________________________________________________________________________

Person(s) Involved, Statements About Incident: _____________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

What Was the Involved Person Attempting To Do:  □ Getting Out of Bed  □ Standing Still  
□ Wheeling in W/C  □ Walking  □ Reaching for Object  □ Transferring To/From Chair or W/C  □ Going to  
the Bathroom  □ Need for Dry Incontinent  □ Other (Specify): _________________________________

Equipment Involved:  □ Walker  □ Cane/Crutch  □ Wheelchair  □ W/C Wheels Locked  
□ W/C/Wheels Unlocked  □ Geri-Chair  □ G/C Back Reclined  □ G/C Back Upright  □ G/C Wheels Locked  
□ G/C Wheels Unlocked  □ Bed  □ Half Bedrails  □ Full Bedrails  □ Bedrails Up  □ Bedrails Down  
□ No Bedrails  □ Other (Specify): ______________________________________________________

Environment:  □ Wet Floor  □ Wet Floor Sign in Place  □ No Sign  □ Object on Walkway  
□ Poor Lighting  □ Rug in Walkway  □ Clutter in Walkway  □ Foot Ware (Specify) __________________
□ New Admit  □ Recent Room Move  □ Call Light in Reach  □ Call Light Not in Reach  
□ Bed/Chair Alarm On  □ Bed/Chair Alarm Off________________________________________________

Diagnosis or Conditions:  □ Vision Deficit  □ Hearing Deficit  □ Hx of Falls  □ Hypotension  □ CVD  
□ Cognitive Deficit  □ Wt. Loss  □ Dehydration  □ Hx CVA  □ New Fx  □ Parkinson’s  □ SOB  
□ Hypertension  □ Diabetes  □ Neuropathy  □ ↓ in ADL’s  □ Other (Specify): ______________________

Medications:  □ Diuretic  □ Antidepressant  □ Hypnotic  □ Anti-anxiety  □ Antipsychotic  
□ Cardiovascular  □ Medication Chg.  □ 9+ Medications  □ Other (Specify): ______________________

Why Did This Incident Occur? (In Your Opinion): ___________________________________________
____________________________________________________________________________________

What Was Done Immediately? (To Prevent Reoccurrence): ___________________________________
____________________________________________________________________________________

Name of Person(s) Completing Report: ____________________________________________________
____________________________________________________________________________________

REVIEW SIGNATURES:  
Administrator __________________  Date  ___________  DON __________________ Date__________
QI ____________________________ Date  ____________ Med. Director __________ Date _________