

PHARMACY RESPONSE - INITIAL FALL INVESTIGATION

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

Facility Name: _____ **Date of Fall:** _____
Resident's Name: _____ **Room #:** _____

- Do not suspect that medication regimen has contributed to cause of fall.
- Resident recently started regimen of _____. Side effects include _____.

Evaluate risk vs. benefit of medication use and decrease dose or discontinue if possible.

Comment: _____

- Resident received a 'PM' dose of _____ approximately _____ hour(s) prior to fall. Peak action of medication is _____ after administration and duration is _____. Side effects include _____.

Consider decreases in dose of medication (if still indicated) or discontinue.

Comment: _____

- Resident receives _____ routinely. Side effects profile includes _____.
- Evaluate risk vs. benefit of medication(s) and decrease dose(s) if possible.

Comment: _____

Pharmacist Signature _____ **Date** _____