THERAPY POST FALL SCREEN

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

Resident _____Room # _____
Date of Fall _____ Referred By _____ Date _____

This section to be completed by Charge Nurse and distributed to Therapy Department

If you know what resident was doing at time of fall, have him/her perform that activity and observe use of appliance, if indicated. Comments.

_____
_____
_____
_____

Observe Resident's usual pattern of interaction within environment prior to fall – if able, i.e. getting in and out of bed, walking, turning, getting in and out of chair, use of bathroom, etc. Comments

_____
_____
_____
_____

Review of Findings/Recommendations to prevent/reduce incidence of falls:

_____
_____
_____
_____
_____
_____
_____
_____

Therapist Signature _____ Date _____