WM
BREASTCARE
WEIRTON MEDICAL CENTER

Fall Risk Assessment Form

1. Are you age **65 or older**? Yes or No
2. Do you have **3 or more diagnosis**? Yes or No
3. Do you have a prior history of **falls within the last 3 month**? An unintentional change in position resulting in coming to rest on the ground or at a lower level. Yes or No
4. Do you have **incontinence**? An inability to make it to the bathroom or commode in a timely manner. Includes frequency, urgency, and/or nocturia. Yes or No
5. Do you have **visual impairment**? Includes macular degeneration, diabetic retinopathies, visual field loss, age related changes, decline in visual acuity, accommodation, glare tolerance, depth perception, and night vision or not wearing prescribed glasses or having the correct prescription. Yes or No
6. Do you have **impaired functional mobility**? May include needing help with ADLs or have a gait or transfer problem, arthritis, pain, fear of falling, foot problems, impaired sensation, impaired coordination or improper use of assistive devices. Yes or No
7. Do you have **environmental hazards**? May include poor illumination, equipment tubing, and inappropriate footwear, pets, hard to reach items, floor surfaces that are uneven or cluttered or outdoor entry and exits. Yes or No
8. Do you have **4 or more prescriptions**? Yes or No
9. Do you have **pain affecting your level of function**? Yes or No
10. Do you have **cognitive impairment**? Could include dementia, Alzheimer's, stroke, confused, use poor judgment, decreased comprehension, impulsivity, memory defects. Yes or No

Name _____

Birthdate _____

Staff Signature and date _____