OUTREACH SERVICES OF INDIANA

FALL ASSESSMENT – FRONT PAGE

TO BE COMPLETED AT TIME OF FALL

NAME:	DOB:	AGE:	DATE:	ADDRESS:
PLACE OF FALL:		TIME OF FALL: ☐ AM ☐ PM		
ACTIVITY IMMEDIATELY BEFORE FALL:				
ACTIVITY AT TIME OF FALL:				

BODY POSITION AT TIME OF FALL		
☐ SITTING	How long?	WHERE: ☐ Chair ☐ Wheelchair ☐ Toilet ☐ Other?
☐ STANDING	How long?	☐ Steady ☐ Unsteady
☐ WALKING	How long?	☐ Steady ☐ Unsteady

IF WALKING, PLEASE ANSWER THE NEXT BLOCK OF QUESTIONS, IF NOT SKIP TO FOOTWEAR SECTION.

TYPE OF ASSISTANCE	**WALKING SURFACE**	**DESTINATION**	**POINT OF PROGRESS**
☐ Without assistance	☐ Flat	☐ Bathroom	☐ Beginning of walk
☐ With Assistance	☐ Incline	☐ Dining Room	☐ Middle of walk
☐ Human	☐ Wet	☐ Living Room	☐ End of walk
☐ Walker	☐ Dry	☐ Shopping	
☐ Handrail	☐ Stairs	☐ Work/Day Program	
☐ Gait belt	☐ Uneven	☐ Other/specify	
☐ Leg brace			

IF PERSON TRIPPED, WHAT DID THEY TRIP ON?

FOOTWEAR	☐ None	☐ Slippers	☐ Socks	☐ Shoes	☐ Adaptive shoes	☐ Sneakers	☐ Other

BEHAVIOR	☐ Happy	☐ Excited	☐ Neutral	☐ Agitated	☐ Angry	☐ Upset
	☐ Other (Specify):					

WHO WAS PRESENT AT TIME OF FALL:

NOISE LEVEL: ☐ Quiet ☐ Some conversation, background noise ☐ Chaotic, much activity and loud noise/music ☐ Other (specify)

Furniture Arrangement	☐ Path free from obstructions ☐ Furniture/objects obstruct path ☐ Recent room reorganization (when/what?)
Lighting	☐ Poorly lit, hard to see ☐ Well lit, easy to see

Known Health Problems/Changes:

What immediate care did person who fell require?

HOW COULD THIS BE PREVENTED IN THE FUTURE?

NAME TITLE OF PERSON COMPLETING ASSESSMENT:

OUTREACH SERVICES OF INDIANA
FALL ASSESSMENT FORM – BACK PAGE
TO BE COMPLETED AT TIME OF IDT REVIEW OF FALL

IDT MEMBERS PRESENT AND DATE OF REVIEW: ____
Change to intervention plan including, if appropriate, schedule, assistance level or environment: _____
Who is responsible for implementing and training for identified changes? _____
Target date for completion of plan changes and training: _____
IS FURTHER ASSESSMENT NEEDED BASED ON IDT REVIEW? ☐YES ☐NO **IF "YES" WHAT TYPE OF EVALUATION DOES TEAM RECOMMEND AND WHAT QUESTIONS NEED TO BE ANSWERED (LIST SPECIFIC QUESTIONS)?** _____
WHAT FOLLOW UP IS NEEDED AFTER EVALUATION RESULTS ARE OBTAINED? _____ **WHO NEEDS TO BE INVOLVED IN THE FOLLOW-UP MEETING?** _____ **WHO IS RESPONSIBLE FOR NOTIFYING NEEDED FOLLOW-UP MEETING PARTICIPANTS?** _____
ANY OTHER INFORMATION FROM IDT NOT INCLUDED ELSEWHERE IN THE REVIEW? _____