FALL RISK CHECKLIST AND INTERVENTION PLAN

(REFER TO "ASSESSING FALL RISK INSTRUCTIONS AND POST-FALL REVIEW" FOR SPECIFIC POTENTIAL RISK ITEMS IN EACH CATEGORY)

Name: _______ Date: _______

CHECK AND SUMMARIZE ALL THAT APPLY:
☐ Client has had previous fall(s): (indicate number, time frame and injuries related to fall in past) _______
☐ Client has chronic or acute conditions increasing fall potential

Plan to address/minimize identified risk(s):

☐ Client has increased potential for injury due to fall because of _______

Plan to address/minimize identified risk(s):

☐ Client has increased potential to fall because of medications

Plan to address/minimize identified risk(s):

☐ Client has functional limitations that increase potential to fall

Plan to address/minimize identified risk(s):

☐ Client has psychological, cognitive or affective conditions that increases fall potential _______

Plan to address/minimize identified risk(s):

☐ Client has environmental or accessibility concerns which increase fall potential _______

Plan to address/minimize identified risk(s):

☐ Other identified issues related to potential for falls not covered such as what documentation and notification need to be made in the event of a fall: _______

Plan to address/minimize identified risk(s):

☐ IDT member responsible for training all staff to competency in implementation of this plan: _______

☐ Team will review and revise this plan as follows (indicate all that apply): ☐ quarterly

☐ in the event of a fall

☐ other (specify) _______
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Completed by (list all):

Reviewed by/Date

Reviewed by/Date

Reviewed by/Date

Reviewed by/Date