SMILES LIKE YOURS FALLS RISK ASSESSMENT FORM

INDIVIDUALS NAME:_____ **DATE:** _____

1. DOES INDIVIDUAL HAVE A HISTOY OF FALLS? YES OR NO? IF YES, EXPLAIN

_____

2. IS INDIVIDUAL EXPERIENCING AGITATION OR DELERIUM? YES OR NO? IF YES, EXPLAIN:

3. ARE THERE ANY MEDICATIONS THATMAY CAUSE DROWSINESS? _____

4. IS THERE A HISTORY OFHYPOTENSION? _____

5. IS THERE IMPAIREDMOBILITY? _____

6. IS THERE IMPAIREDVISION? _____

7. FrequentToileting? _____

8. Low/High BloodSugar? _____

9. Are intoxicated or withdrawing from alcohol or otherdrugs? _____

10. Have impaired mental Status ?_____

Score Yes = 5pts No= 0pts

If the answer is yes, the individual will be given 5 points. If the answer is no, the Individual will be given 0 points. All the points will be added up to produce the individuals score. Based upon the individuals score, the prevention program will be determine. The table below defines the score, the risk type and which program to implement.

SCORE	Risk Type	Implement
5-10	Low Risk	Low Prevention Program
15-25	Medium Risk	Medium Prevention Program
30-50	High Fall Risk	High Prevention Program