# Office of Aging & Adult Services: Fall Assessment Form

**(To be submitted with the DHH HCBS Critical Incident Report Form Critical Incident Description)**

**Participant Name:**_____

**Participant Age:** _____ **Date of Fall:** _____

**Day of Week:** _____ **Time of Fall:** _____

**1. Was the fall observed?** ☐**Yes** ☐**No**

**If Yes, by whom:**_____

**2. Location of fall (be very specific):**_____

_____

**3. Was the participant alone at time of fall?** ☐**Yes** ☐**No**

**4. Has this participant fallen before?** ☐**Yes** ☐**No**

**5. Look at the surroundings where the fall occurred for evidence of the following:**

| | Yes | No | Comments |
|---|---|---|---|
| Water spills? | ☐ | ☐ | |
| Clutter? | ☐ | ☐ | |
| Telephone/TV cords? | ☐ | ☐ | |
| Poor lighting? | ☐ | ☐ | |
| Furniture in the way? | ☐ | ☐ | |
| Wheelchair unlocked? | ☐ | ☐ | |
| Wheelchair footrests in way? | ☐ | ☐ | |
| Rugs/Carpets/floor uneven/slippery? | ☐ | ☐ | |
| Other | ☐ | ☐ | |

**6. Ask the participant: A. Why do you think you fell?**

_____

_____

**B. When you fell, were you:**

| | Yes | No | N/A | Comments |
|---|---|---|---|---|
| In a hurry? | ☐ | ☐ | ☐ | |
| Using your cane/walker/other assistive device? | ☐ | ☐ | ☐ | |
| Tired/weak? | ☐ | ☐ | ☐ | |
| Reaching for something? | ☐ | ☐ | ☐ | |
| Barefoot? | ☐ | ☐ | ☐ | |

| | | | | |
|---|---|---|---|---|
| Hungry? | ☐ | ☐ | ☐ | |
| Did you need to use the bathroom? | ☐ | ☐ | ☐ | |
| Did your clothing get in the way? | ☐ | ☐ | ☐ | |
| Other | ☐ | ☐ | ☐ | |

**7. Have there been any recent changes to the participant's health status that might have caused or contributed to the participant falling? Check all that apply.**

| | Yes | No | Comments |
|---|---|---|---|
| New/increase/decrease in medications? | ☐ | ☐ | |
| Weakness/fatigue? | ☐ | ☐ | |
| Dizziness? | ☐ | ☐ | |
| Blood pressure changes? | ☐ | ☐ | |
| Recent return from hospital/health care facility? | ☐ | ☐ | |
| Recent weight loss? | ☐ | ☐ | |
| Pain level? | ☐ | ☐ | |
| Decrease in food/fluid intake? | ☐ | ☐ | |
| Recent fever/cough/cold? | ☐ | ☐ | |
| Change in diagnosis/condition? | ☐ | ☐ | |
| Change in mental status? | ☐ | ☐ | |
| Change in behaviors? | ☐ | ☐ | |
| Change in mobility? | ☐ | ☐ | |
| Recent changes in blood sugars? | ☐ | ☐ | |
| Other | ☐ | ☐ | |