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

_____