PHARMACIST FALL RISK ASSESSMENT

(This tool is only an example. Please adapt it to meet the needs of your facility and residents.)

Resident Name _____ Admission Date: _____

Circle appropriate numbers and repeat this assessment every 6 months.

SECTION I: HISTORY OF FALLS

One to two falls in a month/quarter	2	Unsteady or shuffling gait	2
More than two falls in a month/quarter	8	Confusion/delirium/disorientation	2
Fall related fracture (date) _____	5	Agitation/increased anxiety	2
Postural hypotension (orthostatic)	1	Syncope/dizziness	1
Sensory deficits: ▪ Decreased hearing 1	▪ Vision 1	▪ Aphasia 1	

Section I Sub-total: _____

SECTION II: MEDICATIONS

Cardiac	1	NSAID	1
Antihypertensive	1	Narcotic analgesic:	
Diuretic	1	Mild	1
Antipsychotic	2	Moderate	2
Hypnotic	2	Anticonvulsant	1
Sedating antidepressant or antihistamine	2	Hypoglycemic	1
Benzodiazepine	2		

Section II Sub-total: _____

SECTION III:

Incontinence:		**Neurological/Psychiatric Disease:**		**Musculoskeletal Disease:**	
Bowel	2	Dementia	1	Arthritis	1
Bladder	2	Parkinsonism	1	Casts/splints/slings	1
Cardiac Disease:		Seizures	1	Prosthesis	1
Arrhythmia	1	Stroke	1		
CHF	1				

Section III Sub-total: _____

Risk Ranges: Minimal 0-3 Moderate 4-7 High risk 8 or more

Total Score: _____

Describe interventions* and re-assess every quarter if above score is 7 or more.
Medication and/or Dosage Changes:

_____
_____
_____
_____
_____
_____

*** Intervention may include:** decrease or change antihypertensive or diuretic; change antianxiety med; increase antiparkinson med or change dosage regimen; change or decrease sedative analgesic or antihistamine to a less sedating one; decrease or change hypoglycemic med.

Pharmacist Signature:_____Date_____