**History of most recent fall**

**Resident’s Name: DOB:**

**Date of Fall:**

How did the fall happen/what caused the fall?

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Where did the fall happen?

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What type of surface did the resident fall on to? (e.g., carpet, laminate floor, concrete or step). ……………………………….……………………………………………………………….……………………………………………………………………………………………………..

What time did the fall happen? ………………………………...………AM/PM

Did the resident see a medical person following their fall? YES/NO

If YES who? …………………………………………………………………………………………………..

Has the same or similar happened to the resident in the last year? YES/NO

If YES please describe, (when, where, how, what time.)

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Is the resident able to get up off the floor independently? YES/NO

If NO, what is the plan to get them up?

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