Falls Risk Assessment Tool

Resident’s Name:

Date of Birth:

Date of Assessment:

Date of next review:

|  |  |  |  |
| --- | --- | --- | --- |
|  | Falls risk identified: | YES | NO |
|  | Has the resident had more than ONE fall in the past year? |  |  |
|  | Has the resident had more than THREE falls in the last month? |  |  |
|  | Does the resident have any difficulties with mobility? |  |  |
|  | Is the resident on FOUR or more different medications per day? |  |  |
|  | Does the resident have any problems with their balance? |  |  |
|  | Does the resident have any health problems that might increase the risk of falls?* Postural hypotension
* Parkinson’s disease
* Cardio vascular problems
* Continence problems
* Cognitive difficulties
 |  |  |

|  |  |  |
| --- | --- | --- |
| Two Yes  LOW RISK | Three Yes MEDIUM RISK | Four or more Yes HIGH RISK |

(Adapted from the Cryer falls risk assessment tool).

Signature:

Designation: