



Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_



Increased Risk of Harm If You Fall

**Fall Risks** (Check all that apply)



History of Falls



Medication Side Effects



Walking Aid



IV Pole or Equipment



Unsteady Walk



May Forget or Choose Not to Call

**Fall Interventions** (Circle selection based on color)

Communicate Recent Fall and/or Risk of Harm



Walking Aids



Crutches



Cane



Walker

IV Assistance When Walking



Toileting Schedule: Every \_\_\_\_\_ hours



Bed Pan



Assist to Commode



Assist to Bathroom

Bed Alarm On



Assistance Out of Bed



Bed Rest

①



1 person

①

②



2 people