PAT0400

FALLS REDUCTION EDUCATION

Falls are a leading cause of accidents for persons of all ages. Falls can be influenced or prevented by understanding several factors. Some falls are age related or caused due to an illness or medical condition. Other factors relate more to the physical environment around a person. Below are suggestions you or a family member should follow to help reduce the risk of falls while receiving rehab therapy at St. Vincent's and in your home environment.

CLINIC

- Ask for assistance with activity if needed.
- Do not attempt unsupervised or new activities without notifying the therapist.
- If using an assistive device (walker, cane, crutches), please use the device properly at all times.
- When assistance is needed, use the "bell" you were provided during treatment or ask for help.
- If you have diabetes, seizures, or low/high blood pressure, please inform your therapist if you are feeling ill or unusual before/during/after treatment.
- If you feel uncomfortable about your fall risk during therapy activities, tell your therapist.
- If you have been prescribed eye glasses or hearing aides, please wear them while at therapy.
- Notify your therapist or primary physician if you experience any falls or changes to your medical condition.
- Take your prescribed medication on a regular schedule; let your therapist know if you need extra time or assistance to maintain your medication routine.
- If you would like assistance in the restroom, entering or exiting the lobby/building let us know so that our staff can assist you.
- If you feel the need for further assessment or have concerns about your risk for falls, let us know.

HOME

- Wear nonskid footwear and use only closed-heel footwear, no open or loose heel.
- Monitor the effects of any medications you take especially if you take multiple medications. Be sure and inform your physician and pharmacist if you feel dizzy or unstable after taking your medication.
- In the bathroom utilize rails for support and nonskid bath mats and floor rugs.
- Eliminate potentially unsafe conditions such as loose rugs, cords, cluttered pathways, poorly lighted areas or stairs without hand rail supports.
- Use path lighting (night lights, flashlights) to help illuminate your pathways to the bathroom during the night.

FALLS ASSESSMENT NEEDS:	
Have you fallen in the past six (6) months?	☐ Yes ☐ No
Do you take ANY of the following prescription medication: narcotics, high blood pressure medications	
Diuretics (water pills), heart medication?	☐ Yes ☐ No
Do you feel dizzy when you get up from a chair or bed?	☐ Yes ☐ No
Do you have uncorrected vision problems that cause difficulty with reading or driving?	☐ Yes ☐ No
Are you over 65 years of age?	☐ Yes ☐ No
• If you answered yes to 2 or more questions, you could be at risk for a fall. • (Therapist further assessment may be indicated)	
FUNCTIONAL NEEDS:	
Have you had a significant DECREASE in your ability to perform any of the following items in the last 3 months?	
Dressing yourself (including shoes, socks, zippers, buttons)?	☐ Yes ☐ No
Feeding yourself (including eating meat, handling utensils)?	☐ Yes ☐ No
Grooming (including shaving, combing your hair, reaching the top and back of your head)?	☐ Yes ☐ No
Walking (causing you to be more dependent on a walker, cane or crutches)?	☐ Yes ☐ No
Climbing stairs or walking up and down curbs or inclines?	☐ Yes ☐ No
In the past 3 months, have you required the use of: ☐ Cane ☐ Walker ☐ Wheelchair ☐ Other: _____	☐ Yes ☐ No
In the past 3 months, have you experienced an increase with choking or problems with swallowing?	☐ Yes ☐ No
In the past 3 months, have you experienced slurred speech or other speech problems?	☐ Yes ☐ No
In the past 3 months, have you had problems remembering the names of objects?	☐ Yes ☐ No
SOCIAL SERVICE NEEDS:	
Do you live alone? If no, with whom do you live? _____	☐ Yes ☐ No
Where do you live? ☐ House ☐ Apartment ☐ Mobile Home ☐ Assisted Living ☐ Nursing Home ☐ Other: _____	
Do you need a caregiver at home?	☐ Yes ☐ No
Do you have access to transportation?	☐ Yes ☐ No
Are your needs for meals, nutrition, and hygiene being met to avoid harm?	☐ Yes ☐ No
Have you experienced abuse including injury, intimidation, or punishment that resulted in physical harm, pain or anguish?	☐ Yes ☐ No

_____ _____ _____
Patient Signature Date Time

Referrals made to the following: _____

By: _____ _____ _____
Date Time

Service:

☐ Fall prevention education information provided to patient / caregiver.

☐ Falls Assessment indicated based on screening and will be documented on the initial evaluation.

_____ _____ _____
Therapist Signature Date Time

ORIGINAL: PATIENT'S MEDICAL RECORD COPY PROVIDED TO PATIENT