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| **Community Falls Risk Screening** |
| **SCREEN ALL PATIENTS AGED 65 OR OLDER. USE CLINICAL REASONING TO SCREEN PATIENTS UNDER THE AGE OF 65** |
| **Date** |  |  |  |  |
| Has the patient fallen in the last 12 months? | Yes\*/No\* | Yes\*/No\* | Yes\*/No\* | Yes\*/No\* |
| Does the patient or relatives report anxiety about risk of falling? | Yes\*/No\* | Yes\*/No\* | Yes\*/No\* | Yes\*/No\* |
| Does the patient report any balance or mobility problems? | Yes\*/No\* | Yes\*/No\* | Yes\*/No\* | Yes\*/No\* |
| Is the patient on 4 or more medications per day? | Yes\*/No\* | Yes\*/No\* | Yes\*/No\* | Yes\*/No\* |
| Has the patient suffered a fracture since the age of 50? | Yes\*/No\* | Yes\*/No\* | Yes\*/No\* | Yes\*/No\* |
| **Signature/Initials** |  |  |  |  |
| If **all** No → no further actionIf **any** Yes → complete Falls Assessment and Care Plan document |