**ALR COMMUNITY – FALL RISK ASSESSMENT**

Individual’s Name: Date:

**Physical Therapy (PT)/Occupational Therapy (OT) Assessment:**

Obtain any PT or OT assessments and review for fall-related information. Enter information as appropriate below.

**Assistive Devices:**

| **Type of Device** | **Does individual have this device?** | **How reliant is individual on device?** | **Does individual use device when needed?** | **Does individual use device correctly?** |
| --- | --- | --- | --- | --- |
| Cane | [ ]  Yes [ ]  No |   | [ ]  Yes [ ]  No | [ ]  Yes [ ]  No |
| Scooter | [ ]  Yes [ ]  No |   | [ ]  Yes [ ]  No | [ ]  Yes [ ]  No |
| Walker | [ ]  Yes [ ]  No |   | [ ]  Yes [ ]  No | [ ]  Yes [ ]  No |
| Wheelchair | [ ]  Yes [ ]  No |   | [ ]  Yes [ ]  No | [ ]  Yes [ ]  No |
| Other: *please specify*  | [ ]  Yes [ ]  No |   | [ ]  Yes [ ]  No | [ ]  Yes [ ]  No |

**Vision:**

Does individual have any visual impairment that puts them at risk for falls?

Does individual wear glasses?

Does individual wear the appropriate glasses to meet their need?

**Medication:**

Does the individual take medications that put them at increased risk for falls?

**Flat Surfaces:**

Does the individual transition well between surfaces (e.g., carpet to tile, carpet to rug, etc.)?

Does the individual navigate objects safely (e.g., furniture, boxes, etc.)?

**Stairs (if applicable):**

Does individual hold onto hand rails?

Does individual place foot fully on stairs?

Does individual miss stairs?

Individual Name: Date of Assessment:

**Other:**

Does individual use furniture or other objects to maintain balance when walking?

Does individual wear well-fitting shoes?

Does individual have any balance issues?

Does individual have history or current issues with dizziness?

Is there any particular time of day that falls occur?

Does individual have any foot issues that may contribute to falls (e.g., numbness)?

**History of falls in the past three months:**

None: [ ]

Number in the last three months:

Location of falls and time of day:

**Any other information relevant to fall risk:**

**Interventions:**

Were any interventions in the past successful in minimizing fall risk?

**Conclusion:**

Can ALR Community develop and implement a care plan that includes specific interventions to minimize falls and keep the resident safe?

**Use of this document does not constitute nor imply compliance with Federal or State rules and regulations. All facilities must follow their own internal guidelines and policies for admission. All facilities are responsible for gathering the appropriate information required to ensure the facility is able to meet the needs of each individual admitted.**

Signature of person completing Assessment:

Individual’s signature: Date: