HealthWest

Fall Follow-Up Form

For Falls Resulting in Emergency Medical Services or Hospitalization

1. Client / Incident Information

Client name:

Date of incident:

Time:

Program / Site / Home:

Person completing form:

2. Circumstances of the Fall

What was the person doing right before the fall?

- ☐ Walking
- ☐ Standing up
- ☐ Sitting down
- ☐ Turning
- ☐ Reaching
- ☐ Transferring
- ☐ Using stairs
- ☐ Carrying items
- ☐ Rushing / moving quickly
- ☐ Other:

What was the environment like? (Check all that apply)

- ☐ Cluttered area
- ☐ Wet or slippery floor
- ☐ Uneven surface
- ☐ Rug or loose flooring
- ☐ Dim / poor lighting
- ☐ Narrow pathway
- ☐ Stairs / threshold
- ☐ Weather conditions (rain, snow, ice)
- ☐ Footwear or clothing affected movement
- ☐ None of the above
- ☐ Other:

How was the person acting or feeling at the time?

- ☐ Tired
- ☐ Rushed
- ☐ Distracted
- ☐ Upset
- ☐ Overstimulated
- ☐ Dizzy / lightheaded
- ☐ Weak
- ☐ In pain
- ☐ Moving quickly
- ☐ Other:

Was the person issued mobility or safety equipment?

- ☐ No
- ☐ Walker
- ☐ Cane
- ☐ Wheelchair
- ☐ Helmet
- ☐ Other:

Were they using it at the time of the fall?

☐ Yes ☐ No ☐ N/A

Please describe how the fall occurred based on what was observed.

3. Injuries and Immediate Response

What injuries were observed?

What immediate care was provided by staff?

4. Emergency Medical Services / Emergency Room / Hospital Follow-Up

Please describe what happened during the Emergency Medical Services, Emergency Room, or hospital evaluation.

Tests completed and results (for example: X-ray, CT scan, labs):

Diagnosis(es):

Treatment provided:

Doctor's recommendations / discharge instructions:

5. Follow-Up Appointments and Referrals

Were follow-up appointments or referrals recommended? ☐ Yes ☐ No

If yes, please list (for example: primary care, neurology, orthopedics, physical therapy):

Appointment date(s):

Outcome(s) (if known):

6. Prevention / Remediation

Was the area where the fall occurred checked for possible safety hazards after the fall?

☐ Yes ☐ No ☐ Not applicable

If yes, were any hazards identified? What was done to correct them?

What other measures are being taken to help prevent another fall?

7. Supporting Documentation

Please return this form with any available documents (check all that are included):

- ☐ Emergency Medical Services report
- ☐ Emergency room record
- ☐ Hospital discharge summary
- ☐ Follow-up appointment information
- ☐ Other: