

CARE HOME STAGE 1: FALLS PREVENTION – PRE-ADMISSION ASSESSMENT

FIRST NAME:	DATE OF BIRTH:	NHS NO:
LAST NAME:		

Please complete the following questions with potential resident / family / referring agency prior to admission to Care Home. Information to assist in development of care plan specific to resident's needs and reduce risk of falls on admission.

How many falls have you had in the last 12 months?						
If you have had a fall / falls, where were you when you fell and what were you doing at the time?						
Have you had any injuries due to a fall?						
Are you or your relatives anxious about your risk of falling?						
<p>Do you use any of the following to help keep you safe?</p> <p>Walking aid <input type="checkbox"/> Raised toilet seat <input type="checkbox"/> Bed rails <input type="checkbox"/></p> <p>Sensor mats <input type="checkbox"/> Hospital bed <input type="checkbox"/> Manual wheelchair <input type="checkbox"/></p> <p>Electric wheelchair <input type="checkbox"/></p> <p>Other – Please state:</p>						
Details of person completing form						
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