Patient Name: **Date:**

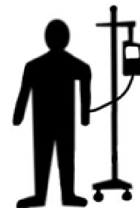
Increased Risk of Harm If You Fall ☐

Fall Risks (*Check all that apply*)

History of Falls ☐

Medication Side Effects ☐

Walking Aid ☐



IV Pole or Equipment ☐

Unsteady Walk ☐

May Forget or Choose Not to Call ☐

Fall Interventions (*Circle selection based on color*)

Communicate Recent Fall and/or Risk of Harm

Walking Aids

Crutches

Cane

Walker

IV Assistance When Walking

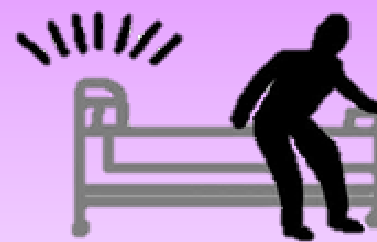
Toileting Schedule: Every ________ hours

Bed Pan

Assist to Commode

Assist to Bathroom

Bed Alarm On



Assistance Out of Bed

Bed Rest

1 person

2 people

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