COLUMBUS COMMUNITY HOSPITAL
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Orthopedics

FALL RISK ASSESSMENT (AGE 65 AND OLDER)
(NOTE: This screening is required by the federal mandate to be completed annually)

Patient Name: _____

Date of Birth: _____

Today's Date: _____

Increased Fall Risk Factors (check each that applies)

_____Diagnosis (do you have 3 or more medical issues?)

_____Do you have a history of falls within the past three months?

_____Incontinence or uncontrolled bladder?

_____Visual Impairment (do you have trouble seeing?)

_____Impaired functional mobility (do you use a cane or walker?)

_____Polypharmacy (do you take more than 3 medications?)

_____Does pain keep you from performing daily activities?

_____ None of the above

History of a fall in the past 12 months YES NO

If yes, were you injured? YES NO

How many falls in the past year? _____