

## Level 2: Multi-factorial Falls Risk Assessment

The form is intended to be completed by any healthcare professional on a primary care team. As local arrangements may vary the assessor/health care professional should complete the form in so far as their scope of practice allows and refer to their colleagues as required for full completion of the appropriate parts. The Clinician who initiates the process should maintain the record of the assessment and a register should be maintained by the Primary Care Team or Administration Support. This register would allow clients to be called back for follow up as required.

Assessor: _____		Date: _____	
Information obtained from: <input type="checkbox"/> Client <input type="checkbox"/> Carer <input type="checkbox"/> Other (Specify _____)			
<b>Demographic details</b>			
Name: _____ Address: _____ Telephone number: _____ Date of Birth: _____ GMS/LTI Card No: _____	Next of kin: _____ Relationship: _____ Tel. No: _____  GP: _____ Address: _____ Tel. No: _____		
<b>Past Medical History</b>			
<b>Social History</b>			
Living Alone <input type="checkbox"/> Yes <input type="checkbox"/> No <span style="margin-left: 100px;">Carer <input type="checkbox"/> Yes <input type="checkbox"/> No</span>			
<b>1. Falls History</b>			
History of Falls: <input type="checkbox"/> Yes <input type="checkbox"/> No			
Number of falls in last 12 months? : _____			
Location of fall(s):   Indoors <input type="checkbox"/> _____   Outdoors <input type="checkbox"/> _____			
Time of the day falls occurred? _____			
How did the fall occur/what was the activity at the time? _____			
What (in the person's opinion) was the cause of the fall(s)? _____			
_____			
Has the person changed their routine or environment since the fall? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>			
Did the person receive any injuries as a result of the fall? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>			
Episodes of dizziness associated with falling? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>			
Episode of blackout <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>			
Was the person able to get up from the floor? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>			
Was the person able to summon help following the fall? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>			
Does the person have a pendant alarm? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>			
(If yes, was the person wearing pendant alarm at time of fall? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>			

Client:		DOB:	
<b>2. Gait and Balance</b>			
Gait analysis (unsteady on feet/shuffles/uneven stride length etc):			
Poor balance: <input type="checkbox"/> Yes <input type="checkbox"/> No Reported difficulty climbing stairs/steps to house: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A Walking aid: <input type="checkbox"/> Yes (please specify): _____ <input type="checkbox"/> No			
<b>3. Functional Ability</b>			
Activities of Daily Living: Ask the client are they: Independent (I), requires Assistance (A), or Dependent (D) with each of the following tasks?			
Personal Activities of Daily Living (Dressing, Bathing, Toileting)		<input type="checkbox"/> I	<input type="checkbox"/> A <input type="checkbox"/> D
Transfers (Toilet, Bed, Chair)		<input type="checkbox"/> I	<input type="checkbox"/> A <input type="checkbox"/> D
Domestic Activities of Daily Living (Housework, Meal Preparation, Shopping)		<input type="checkbox"/> I	<input type="checkbox"/> A <input type="checkbox"/> D
<b>4. Fear of Falling</b>			
Fear of falling or restricting any activity they appear capable of doing		<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, details: _____			
<b>5. Home Safety</b>			
Does the client have:			
Steps / Stairs in the home either inside or outside unprotected by a rail?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
A shower with step or a bath without grab rails?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Indoor hazards present (cluttered rooms, rugs, cords)		<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>6. Perceived Functional Ability</b>			
Demonstrates decreased awareness in reporting falls, risks and consequences of falls		<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>7. Cognitive Function</b>			
Complete The Abbreviated Mental Test Score – Appendix 7			
<b>8. Urinary Incontinence</b>			
Urinary Incontinence <input type="checkbox"/> Yes <input type="checkbox"/> Urgency <input type="checkbox"/> Nocturia <input type="checkbox"/> Other _____ )			
<input type="checkbox"/> No			
<b>9. Foot Problems and Footwear</b>			
Foot problems i.e. corns, bunions, swelling, overgrown toenails		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Inappropriate, poorly fitting or worn footwear		<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>10. Assessment of Mood</b>			
During the last month have you been bothered by feeling sad, depressed or hopeless?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
During the last month have you often had little interest or pleasure in doing things?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>11. Nutrition</b>			
<b>11(i)</b>			
Weight loss (within previous 12 months)		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Loss of appetite		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are there issues impacting on dietary intake		<input type="checkbox"/> Yes	<input type="checkbox"/> No
(If client answers "yes" carry out 11(ii) as appropriate ("MUST" screening - refer to MUST tool in Appendix 4)			
<b>11(ii) "MUST" screening:</b>			
Height :	Weight (kg):	BMI (kg/m <sup>2</sup> ):	"MUST" Score: _____ 0 – Low risk: Monitor. 1 – Med risk: Implement 'First Line Dietary' advice (Appendix 4). ≥ 2 – High risk: Implement 'First Line Dietary' advice (Appendix 4) & refer to dietitian.

Client:	DOB:
<b>12. Bone health</b>	
Previous low trauma fracture	<input type="checkbox"/> Yes <input type="checkbox"/> No
Xray evidence of osteopenia	<input type="checkbox"/> Yes <input type="checkbox"/> No
Corticosteroid Use (i.e. prednisolone for ≥3months)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Family history of osteoporosis (especially maternal hip fracture)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Other clinical risk factors: height loss, kyphosis, low Body Mass Index (<19kg/m <sup>2</sup> )	<input type="checkbox"/> Yes <input type="checkbox"/> No
Possible secondary osteoporosis (primary hyperparathyroidism, poorly controlled thyrotoxicosis, malabsorption, rheumatoid arthritis, liver disease, alcoholism, primary hypogonadism)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Untreated oestrogen deficiency (history of surgical or natural menopause <45 years, secondary amenorrhoea > 6 months not due to pregnancy or primary hypogonadism)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
<b>13. Drug History</b>	
<b>Medications:</b>	
Is the client on 4 or more medications?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is the client on psychotropic medication, e.g. night sedation, anti depressants, anxiety meds?	<input type="checkbox"/> Yes <input type="checkbox"/> No
List all medications (including dosage): Document below or attach print out	
<b>Alcohol:</b>	
Does the client have alcohol dependency issues?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, alcohol units per week: _____	
<b>14. Vision</b>	
15(i) Does person report any vision related problems e.g. poor eyesight, cataracts etc.? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>	
<i>(If client answers "yes" complete part (ii) below or complete onward referral for completion)</i>	
Under 70: Has the client had an eye test in last 2 years?	<input type="checkbox"/> Yes <input type="checkbox"/> No
70 or over: Has the client had an eye test in last year?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does the client wear bifocals?	<input type="checkbox"/> Yes <input type="checkbox"/> No
15(ii) Visual acuity test: R = L =	
Are visual fields normal?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>15. Clinical observations</b>	
Record BP and HR after 2 minutes lying:	BP: ____/____ HR: ____
Record BP and HR after 1 minute standing:	BP: ____/____ HR: ____
(Postural hypotension: fall of 20mmHg systolic or 10mmHg diastolic with dizziness)	
Assessor:	Date:
Profession:	

Client:		D.O.B.:	
Problems identified		Actions to be Taken	
Onward referral:			
<input type="checkbox"/> GP <input type="checkbox"/> Nursing <input type="checkbox"/> PT <input type="checkbox"/> OT		<input type="checkbox"/> Dietitian <input type="checkbox"/> Social Work <input type="checkbox"/> Psychology <input type="checkbox"/> Chiropody <input type="checkbox"/> Podiatry <input type="checkbox"/> Comprehensive Geriatric assessment <input type="checkbox"/> DEXA Scan <input type="checkbox"/> Other	
Comments/Additional information :			
Date:	Comments:		Signature/Name Printed
Form Completed By :			
Date:	Professional:	Sections Completed:	Signature/Name Printed



Féilthmeannacht na Seirbhíse Sláinte  
Health Service Executive

XXX Primary Care Team

Date: \_\_\_\_\_

Dear \_\_\_\_\_,

I have conducted the Multi-factorial Falls Risk Assessment on

Client Name: \_\_\_\_\_

Client Address: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Client Date of Birth: \_\_\_\_\_

I would be grateful if you would complete the following sections of the Multi-factorial Falls Risk assessment:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please return your completed sections me at the address below and please contact me with any further enquiries regarding this matter.

Thank you

Signature: \_\_\_\_\_

Name: \_\_\_\_\_

Profession: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Contact Phone No.: \_\_\_\_\_

***Please attach a copy of the Multifactorial Falls Risk Assessment with this letter.***

*National Care of the Elderly and Primary Care Clinical Programmes – November 2012*

REFERENCE: HSE, Dept. of Health and Children (2008) 'Strategy to Prevent Falls and Fractures in Ireland's Ageing Population'. National Council on Aging and Older People, Report of the National Steering Group on the Prevention of Falls in Older People and the Prevention and Management of Osteoporosis throughout life. Available from [www.hse.ie](http://www.hse.ie).