

# Falls Clinic

*Day Hospital, Department of Health Care of the Elderly*

Name:  
D.O.B.:

Hosp No:  
GP:

Referred from:  
Clinic Dr:

Date referred:  
Date of clinic:

**Fall History**

First fall: Y / N

No of falls in previous year:

Location of fall: Outdoors /Stairs / Kitchen / Bathroom / Living Room / Bedroom / Other

Was fall witnessed: Y / N

Definite slip/trip: Y / N

Associated dizziness: Y / N

LOC: Y / N

Palpitations: Y / N

Able to get self off floor: Y / N

Time on floor (mins):

Injuries sustained from fall \_\_\_\_\_

**Medical History**

- Heart disease
- Stroke
- COPD/Asthma
- Hypertension
- Diabetes
- Degenerative joint disease
- Cognitive impairment
- Visual impairment
- Syncope
- Epilepsy
- Incontinence
- Other - (please state) \_\_\_\_\_

**Full Drug History**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Alcohol: \_\_\_\_\_ units/week

Smoking: \_\_\_\_\_ cigarettes/day

**Social Circumstances**

**Lives in: Flat / House / Bungalow / WCF / Residential Home / Nursing Home**

**Lives alone: Y / N**

**Stairs: Yes / No**

**Lambeth / Southwark / Other**

**Usually able to go out: Yes / No**

**Mobility: Independent  
Stick  
Frame  
Wheelchair**

**Services: MOW  
HH  
Personal Care  
District Nurse  
Day Centre  
Day Hospital**

**Carer: None  
Spouse  
Other family  
Friend/neighbour**

**Examination**

**AMT**

**Age**

**Time (to nearest hour)**

**Address for recall**

**Year**

**Location**

**Recognition of two persons**

**Date of Birth**

**WW2**

**Present monarch**

**Count backwards 20 – 1**

**Weight: \_\_\_\_\_ kg**

**Height: \_\_\_\_\_ m**

**Pulse: \_\_\_\_\_ bpm**

regular / irregular

**BP sitting:**

**BP standing:**

**Visual acuity**

**R Eye**

**L Eye**

**Score: \_\_\_\_\_ /10 (If <8 do MMSE)**

**CVS:**

**Carotid bruits: Yes / No**

**Valvular defect: Yes / No**

**LVF: Yes / No**

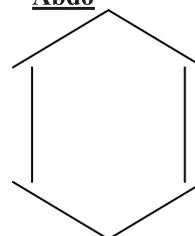
**RHF: Yes / No**

**CCF: Yes / No**

**RS**



**Abdo**



**Cranial Nerve Deficit:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Visual Fields: L Eye R Eye**



**Cataract Formation: Yes / No**

**Hearing: Normal / Shout / Hearing Aid**

**PNS:**

***Tone***

R Arm	L Arm
R Leg	L Leg

***Reflexes***

	R	L
Biceps		
Triceps		
Supinator		
Knee		
Ankle		
Plantars		

**Power**

***Arms***

- Shoulder abduction
- Shoulder adduction
- Elbow flexion
- Elbow extension
- Wrist flexion
- Wrist extension
- Finger abduction
- Finger adduction
- Opposition

	R	L

***Legs***

- Hip flexors
- Hip extensors
- Knee flexion
- Knee extension
- Ankle dorsiflexion
- Ankle plantiflexion

	R	L

***Lower limb***

- Sensation Intact: Yes / No
- Proprioception intact: Yes / No
- Vibration intact: Yes / No

***Joint deformities***

- Hands
- Elbows
- Shoulders
- Spine
- Hips Knees
- Ankles

- Good foot care: Yes / No
- Sensible footwear: Yes / No

**Timed Up and Go: \_\_\_\_\_secs**

**MMSE (if indicated) \_\_\_\_\_/30**

**GDS – 15 Question Form \_\_\_\_\_/15**



# PROFET – Environmental Assessment

Name:

Number:

			At time of fall	In the home	In the environment
<b>Slip Hazards</b>	<b>1</b>	Liquid/solid spills			
	<b>2</b>	Wet floors			
	<b>3</b>	Incorrect footwear			
	<b>4</b>	Loose mats on polished floors			
	<b>5</b>	Rain, sleet, snow, ice			
	<b>6</b>	Change from wet to dry surface			
	<b>7</b>	Unsuitable floor surface			
	<b>8</b>	Dusty floors			
	<b>9</b>	Sloping surfaces			
<b>Trip Hazards</b>	<b>10</b>	Loose floorboards / tiles			
	<b>11</b>	Loose and worn mats / carpets			
	<b>12</b>	Uneven outdoor surfaces			
	<b>13</b>	Holes / cracks			
	<b>14</b>	Change in surface level – ramps, steps, stairs			
	<b>15</b>	Cables across walking areas			
	<b>16</b>	Obstructions			
	<b>17</b>	Bumps, ridges and protruding nails etc			
	<b>18</b>	Low wall and floor fixtures, door catches, door stops etc.			
<b>Risk Factors</b>	<b>19</b>	Organisation of walkways			
	<b>20</b>	Badly placed mirrors / reflections from glazing			
	<b>21</b>	Poor or unsuitable lighting			
	<b>22</b>	Wrong cleaning regime / materials			
	<b>23</b>	Moving goods, carrying, pushing or pulling a load			
	<b>24</b>	Rushing around			
	<b>25</b>	Distractions			
	<b>26</b>	Fatigue			
	<b>27</b>	Effects of alcohol			
	<b>28</b>	Effects of other drugs			
	<b>29</b>	Other factor (describe)			

# Falls Assessment Proforma

Accident & Emergency, Department of Health Care of the Elderly  
Falls Specialist Practitioner – Bleep 929 Mon-Fri

Name: \_\_\_\_\_ Hosp No \_\_\_\_\_ Attending Dr \_\_\_\_\_

Date of attendance: \_\_\_\_\_ Time: \_\_\_\_\_

## Fall History

First fall: \_\_\_\_\_ Y / N

\*No of falls in previous year:  (>1 = high risk)

\*Location of fall: Indoors / Outdoors (indoors = high risk)

Was fall witnessed: \_\_\_\_\_ Y / N

Definite slip/trip: \_\_\_\_\_ Y / N Associated dizziness: \_\_\_\_\_ Y / N

LOC: \_\_\_\_\_ Y / N Palpitations: \_\_\_\_\_ Y / N

\*Able to get self off floor: \_\_\_\_\_ Y / N (N=high risk) Time on floor (mins): \_\_\_\_\_

## Medical History

## \*Full Drug History (4+ meds = high risk)

Heart disease \_\_\_\_\_  
 Stroke \_\_\_\_\_  
 COPD/Asthma \_\_\_\_\_  
 Hypertension \_\_\_\_\_  
 Diabetes \_\_\_\_\_  
 Degenerative joint disease \_\_\_\_\_  
 Cognitive impairment \_\_\_\_\_  
 Visual impairment \_\_\_\_\_  
 Syncope \_\_\_\_\_  
 Epilepsy \_\_\_\_\_  
 Incontinence \_\_\_\_\_  
 Other - (please state) \_\_\_\_\_

Smoking: \_\_\_\_\_ no/week

Alcohol: \_\_\_\_\_ units/week

## Social Circumstances

Lives in: Flat / House / Bungalow /Maisonette/ WCF / Residential Home / Nursing Home

Lives alone: Y / N Stairs: Yes / No

Lambeth / Southwark / Other Usually able to go out: Yes / No

<b>Mobility:</b> Independent	<b>Services:</b> MOW	<b>Carer:</b> None
Stick	HH	Spouse
Frame	Personal Care	Other family
Wheelchair	District Nurse	Friend/neighbour
	Day Centre	
	Day Hospital	

**Examination**

GCS: BM  
Temp: Pulse: BP; Lying / Standing /

**AMT**

- Age
- Time (to nearest hour)
- Address for recall
- Year
- Location
- Recognition of two persons
- Date of Birth
- WW2
- Present monarch
- Count backwards 20 – 1

Score: /10

***Relevant Systems Examination***

***Current Level of Function***

- No change from pre-fall level of function
- Decreased mobility/function but able to go home
- Decreased mobility/function – unable to discharge

**Results**

---



---



---

**Conclusions**

Likely cause of fall: simple slip/trip, acute illness, multifactorial, unexplained

**Comments**

---



---



---

**\* High risk – recommend referral to Falls Clinic if Falls Nurse not available to assess**

**Outcome:**

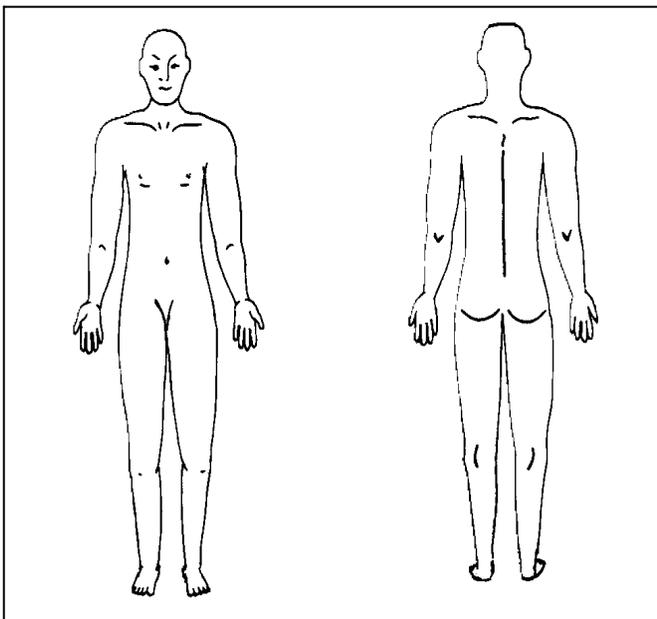
- Home with GP letter
- Admit to CDU
- Refer to Falls Clinic / Day Hospital
- Refer to Rapid Response
- Refer to DHE (Out-Patients)
- Refer for hospital admission

Signature: \_\_\_\_\_ Print Name: \_\_\_\_\_ Date: \_\_\_\_\_

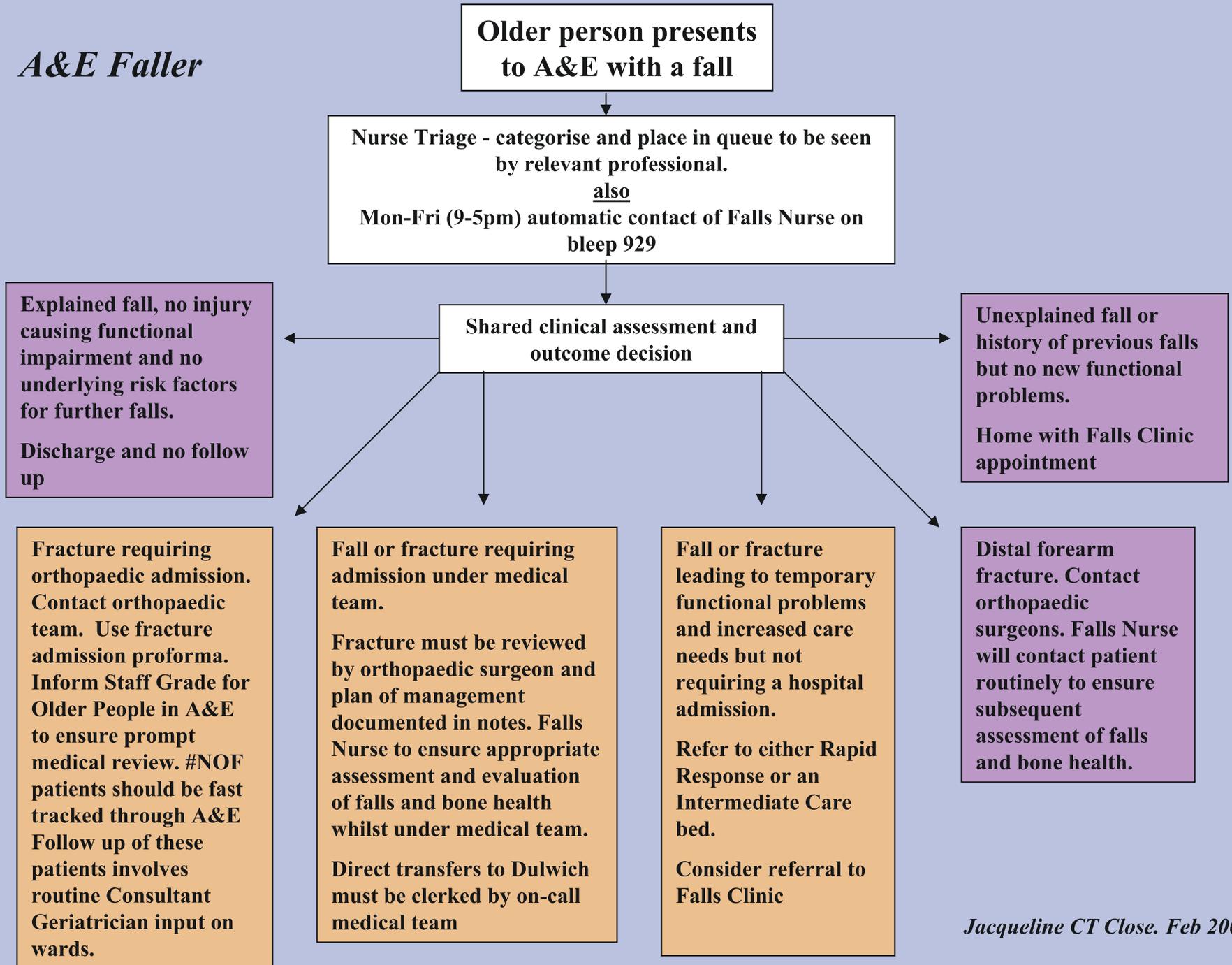
**Injuries Sustained**

- Head injury – no laceration
- Head injury - laceration
- Fracture \_\_\_\_\_
- Laceration requiring stitches \_\_\_\_\_
- Laceration but no stitches \_\_\_\_\_
- Superficial bruising \_\_\_\_\_
- No injury

**Indicate site of injury including pressure areas**

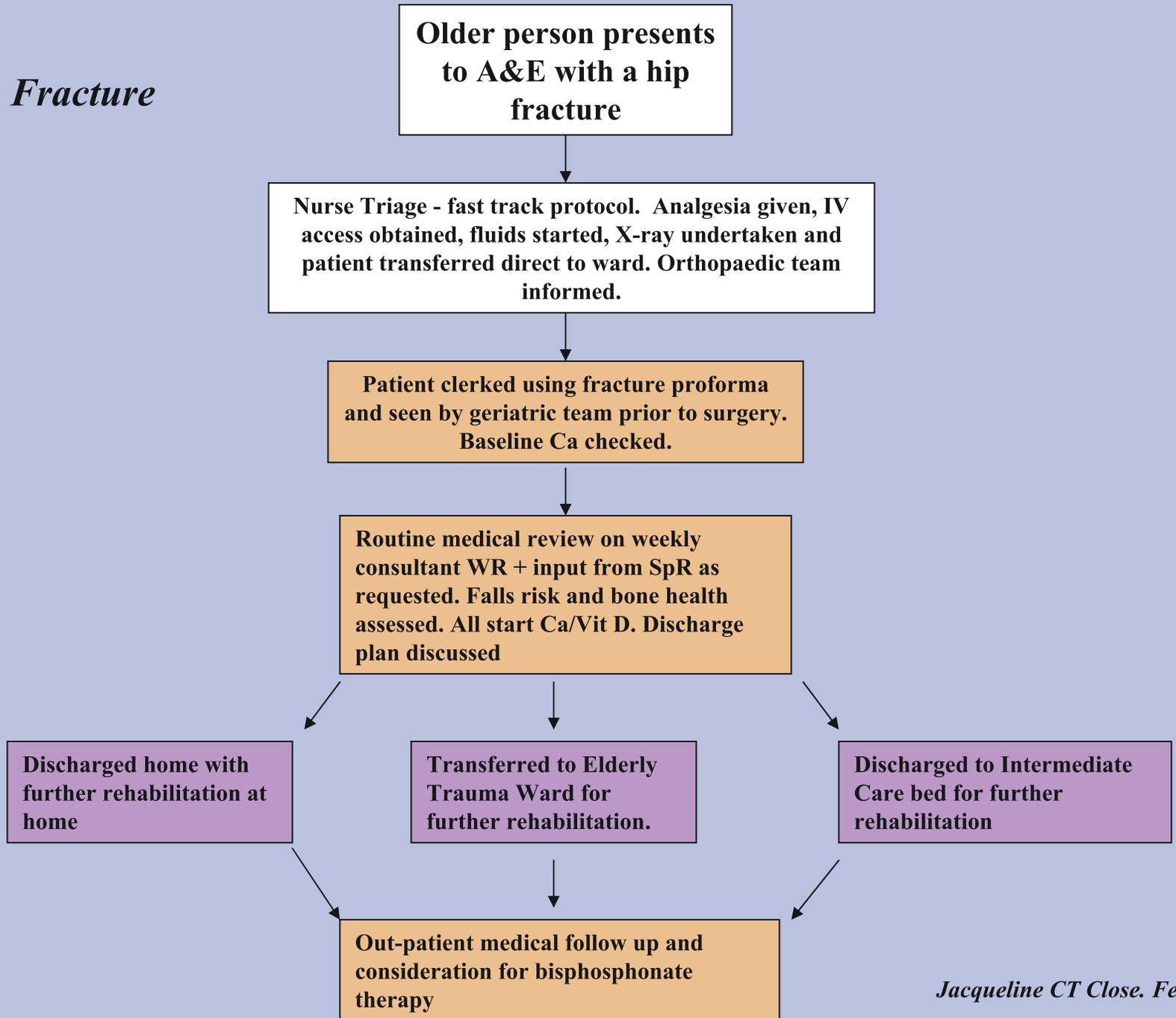


# *A&E Faller*



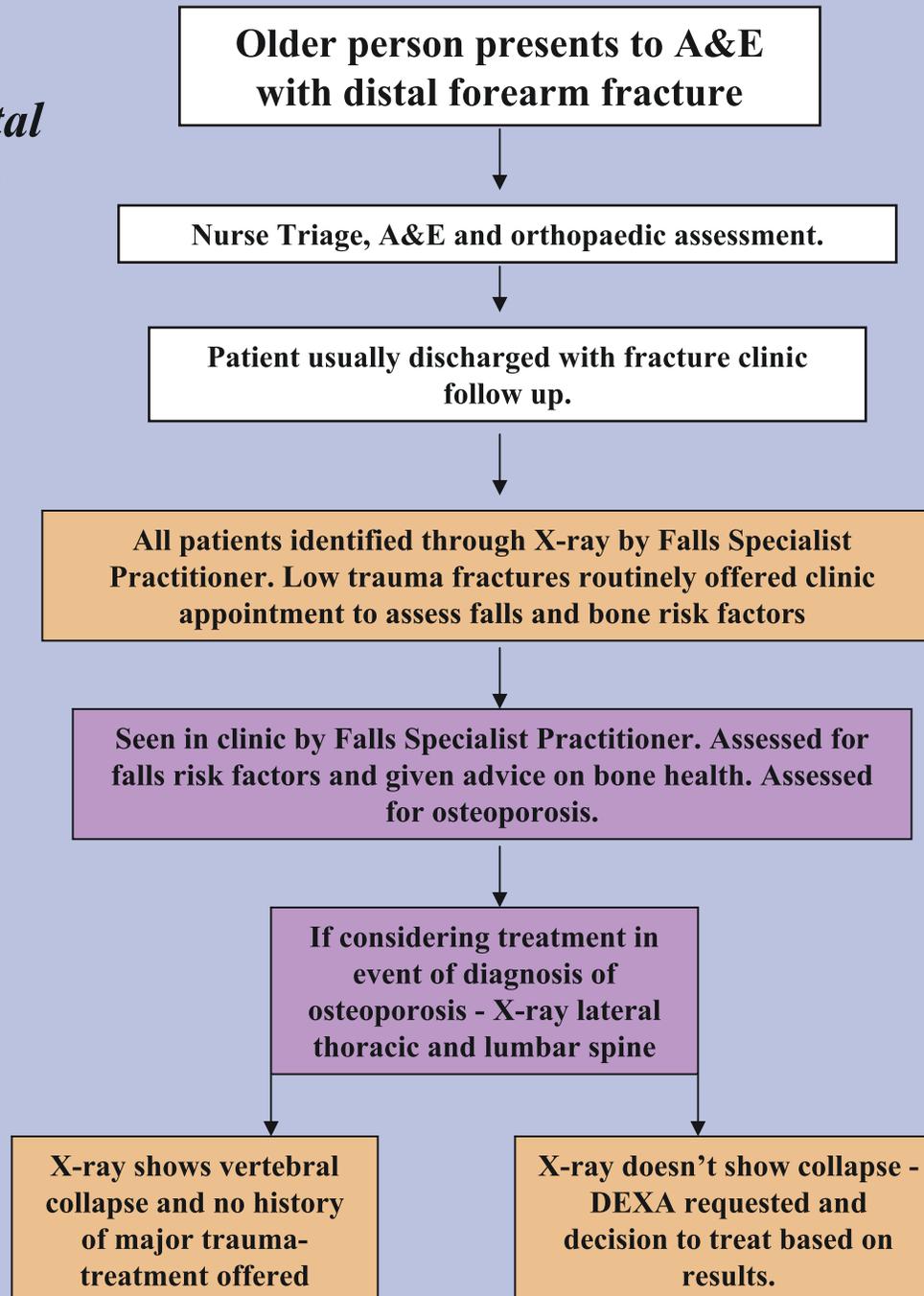
*Jacqueline CT Close. Feb 2003*

# Hip Fracture



Jacqueline CT Close. Feb 2003

*Low trauma distal forearm fracture*



*Jacqueline CT Close. Feb 2003*