EMERGENT CARE FOR INJURY CAUSED BY FALL OR ACCIDENT AT HOME REVIEW TOOL

Patient ID#: Age: M F SOC Date: D/C Date:

Primary Dx: Secondary Dx:

Fall? Yes No Accident? Yes No Time of Fall/Accident AM PM

Criteria	Yes	No	Comment
1. Live alone?			
2. Caregiver?			
3. Use Assistive Device?			Which one?
4. Prior to fall/accident, was patient safety evaluation done?			
5. If safety recommendations made, did patient implement them?			
6. What services were in place before: Nursing PT OT HHA			
7. Services after fall/accident: Nursing PT OT HHA			
8. Documentation of fall/accident?			
9. Prior did HHA see pt. within 72 hrs.			
10. Was there an injury?			What
11. ED Visit?			
12. Physician notified?			
13. Hospitalized?			
14. Could fall have been prevented?			
15.Were safety measures implemented after the fall/accident?			
16. Taking any medication that could have contributed to fall/accident?			
17. Patient's mental status? Oriented Confused			

Depressed Irrational/Agitated			
18. What was the possible cause? Muscular/Skeletal Unsteady gait Faint/Dizzy Tripped Not using assistive device Cognitive Impairment Medications Acute Illness Other			 BP On what Explain
19. Incident Report completed?			

District: MN SW Mel

Most recent OASIS: MO670 MO690

MO680 MO700

Additional comments:

Completed By: