XYZ HHA
Incident Report - Falls

Patient _____ Date of Fall
Number of falls in past 3 months: _____ Witnessed by Agency staff? "Yes "No

Location of fall: Bathroom Bedroom Other: _____

Contributing Factors:

Transferring	Lost Balance	Fell out of bed	Fell out of chair
Dizzy	Did not use assistive device		Mental Status changes
Clutter in fall area	Throw rug/loose rug		Lack of adaptive equipment
Water on floor	Improper foot wear		Trip hazard - wires, catheter, etc.

Describe the fall and situation surrounding the fall: _____

_____

_____

_____

Ortho BP check done Sitting/Lying_____ Standing

Injury:

None Noted	Possible Fracture	Altered level of consciousness
Bruising	Soreness	Pain
Skin tear/laceration	Abuse/neglect suspected?	

Describe injury and treatment: _____

_____

_____

_____

Dr. notified? Yes No Response

Education Provided

Need for use of assistive device and/or supervision	Request for PT Referral
Orthostatic hypotension precautions	Request for OT Referral
Environmental Changes Needed	Request for SW Referral
Request for Dietician Referral	

Other: _____

_____

Staff member signature: _____ Date: _____