FALL INCIDENT REPORT

The following information is confidential. This report may not be photocopied and *is not* part of the medical record.

DATE & TIME OF FALL:_____ DATE REPORTED:_____

____ Patient ____ Visitor ____ Volunteer ____ Outpatient ____ Other_____

NAME:_____ AGE:_____ ROOM #_____ ADM. #_____ Male Female

(Make sure you document information about the fall in the Nurses Notes if this is a patient. DO NOT REFER TO THE REPORT)

ADMISSION DIAGNOSIS:_____ or N/A

LOCATION OF FALL:_____ BRIEF DESCRIPTION OF FALL:_____

_____

_____

_____

ACTION TAKEN TO PREVENT FALL FROM RECURRING:_____

_____

_____

VITAL SIGNS:_____ FALL RISK LEVEL: I II III

CONDITION PRIOR TO FALL: ___Alert ___ Confused/disoriented ___ Neurologically impaired ___ Sedated

___Intoxicated/Substance abuse ___ Lost balance/dizzy ___ Fainted ___ OTHER:_____

ENVIRONMENTAL CONDITIONS: ___ Call light in reach ___ Side rails up: **X2 X4** ___ Bed position: **Low Raised**

___ Floor wet ___ **Restraint on**: *Vest Wrist Lap belt* **Applied properly?** *Yes No*

___ Bed Check: *Yes No* **Worked properly?** *Yes No* **Was it turned on?** *Yes No*

If Bed Check did not work properly, replace it immediately and send it to Maintenance for check. Serial #?_____

MEDICATIONS PRIOR TO FALL:_____

POSSIBLE CAUSES: ___ Ambulating without calling for assistance ___ Chair or equipment ___ Improper footwear

___ Incontinent ___ Side rails lowered ___ Side rails refused ___ Restraints refused ___ Removed restraints

___ Unable to follow instructions ___ OTHER:_____

PHYSICIAN NOTIFIED?: *Yes No* **DR._____ DATE & TIME:_____**

INJURIES? *NONE* or LIST:_____

TREATMENT: ___ NONE ___ MINOR (heat, cold, dressing) ___ SIGNIFICANT (X-ray, sutures, tests)

___ MAJOR (treatments, surgery) ___ OTHER:_____

PHYSICIAN SIGNATURE:_____ *NOTED* or *Comments*:_____

_____

FAMILY NOTIFIED?: *Yes No* Person notified:_____ Date & Time_____

REPORTED BY:_____ SHIFT SUPERVISOR:_____

11/04