Multifactorial Falls Risk Assessment.		Sheffield Integrated Falls Pathway	
Name of Professional: Signature..... Date..... Designation: Contact no. Base / Service:		**Client Name:** DOB: Address: Cons: Ward: Hospital no. NHS no. Tel no:	
Information collected from: **Patient / Carer** Consider mental capacity / best interests when explanation of assessment given & consent obtained. Signature..... Date.....		GP: Address: Tel:	
History of Falls: How many falls in last 6 months?		Unexplained-further assessment required Explained-and further assessment required	
Activity at time? When? Where? Pattern?			
			Date:
Any signs of infection? Eg ear, chest, UTI	Y / N	Ref to Doctor	
Any black outs or loss of consciousness before falling?	Y / N	Ref to Doctor / Specialist services	
Any dizziness before falling?	Y / N	Taking BP: Lie patient flat for 5 mins and record. Then repeat at 1 & 3 mins in standing.	
Any dizziness on standing or turning?	Y / N	**Lying** BP = **Standing** 1 min = 3 min = Symptomatic on standing? Y / N Ref to Dr (name)	
Taking four or more medications – and no recent review? Taking drugs associated with increased falls risk? Started on any new drugs / dose?	Y / N Y / N Y / N	Ref to Doctor / Pharmacist for review name..... eg sleeping tabs, antidepressants, antihypertensives, antipsychotics, antiparkinson's, diuretics – when?.....	
Bone Health: Known to have osteoporosis?	Y / N		
Any bone fracture since the age of 40? Taking oral steroids or have done previously?	Y / N Y / N	Ref to Doctor for further assessment / investigation / Calcium and Vit D therapy.	
Concern of falling: Client 'concerned' about falling or has poor confidence with mobility?	Y / N	**FES – I (short)** Score = Ref to : - Therapy services..... Citywide Care Alarms + / or Telecare	
Cognitive Impairment/Mental Capacity: Any memory problems? Any Anxiety / Depression? Known to Mental Health (MH) Services	Y / N Y / N Y / N	**MMSE =** **HADS: A =** **D =** Ref to MH Services / Doctor.....	
Vision Wears glasses? Any change in vision? Has related pathology?	Y / N Y / N Y / N	Check glasses are clean. Recommend annual vision check. Brincliffe House have list of domiciliary opticians (Tel: 2263114)	
Hearing: Wears hearing aid /s?	Y / N	Check hearing aid works. Check for ear wax. Ref to Audiology / Hearing Services	