Resident Name:	**Resident Number:**	**Effective Date:**
Location:	**Admission Date:**	**Medical Record #:**
Date of Birth:	**Physician:**	
Allergies:		

1.	**Reason for Assessment Request**	**A.** ◯ 1. Recent Falls ◯ 2. Changes in Functional Ability ◯ 3. New Admission ◯ 4. Change in Physical Device Use ◯ 5. Quarterly Assessment ◯ 7. Annual Assessment ◯ 8. Significant Change ◯ 9. Other **B.** List reason if other:
1a.	**Morse Fall Risk Assessment/Scale**	**1.** History of Falls ◯ 25. Yes ◯ 0. No **2.** Applicable/Contributing Secondary Diagnosis ◯ 15. Yes ◯ 0. No **3.** Ambulatory Aid ◯ 30. Furniture ◯ 15. Crutches/Cane/Walker ◯ 0. None/Bed Rest/Confined to Bed/Confined to Chair/Nurse **4.** IV/Heparin Lock ◯ 20. Yes ◯ 0. No **5.** Gait/Transferring ◯ 20. Impaired ◯ 10. Weak ◯ 0. Normal/Confined to Bed/Immobile **6.** Mental Status ◯ 15. Forgets Limitations ◯ 0. Oriented to Own Ability **7.** Total **8.** Morse Fall Scale ◯ 1. High Risk 45 and Higher ◯ 2. Moderate Risk 25-44 ◯ 3. Low Risk 0-24
2.	**History of Falls Prior to Admission**	◯ 0. No History ◯ 1. 1-2 ◯ 2. 3-4 ◯ 3. 5 or greater
3.	**History of Falls within last six months**	◯ 0. No History ◯ 1. 1-2 ◯ 2. 3-4 ◯ 3. 5 or greater
4.	**Medication Use**	Medication taken more than 3 x /week, including prn's 1. ☐ Antihistamines

Resident Name:	Resident Number:	Effective Date:
Location:	Admission Date:	Medical Record #:
Date of Birth:	Physician:	
Allergies:		

4.	**Medication Use**	Medication taken more than 3 x /week, including prn's 2. ☐ Diuretics 3. ☐ Hypoglycemic Agents 4. ☐ Antiseizure/Antiepileptics 5. ☐ Antihypertensives 6. ☐ NSAID'S 7. ☐ Benzodiazepine's 8. ☐ Narcotic's 9. ☐ Psychotropics 10. ☐ Anti-Parkinson's 11. ☐ Cathartic's 12. ☐ Sedatives/Hypnotic's 13. ☐ Antispasmodics 14. ☐ Antiarrythmics 15. ☐ If medication &/or dosage has changed in last 5 days 16. If 15. checked, describe changes in medications. 17. ☐ None of the above
4a.	**Medical Conditions**	Check all that apply. 1. ☐ Osteoporosis 2. ☐ Arthritis (Osteo/Rheumatoid) 3. ☐ Hypertension 4. ☐ Hypotension 5. ☐ Cerebrovascular Accident 6. ☐ Cardiovascular Disease 7. ☐ Peripheral Vascular Disease 8. ☐ Diabetes 9. ☐ Chronic Respiratory Disease 10. ☐ Parkinson's 11. ☐ Multiple Sclerosis 12. ☐ Unspecified Tremors 13. ☐ Peripheral Neuropathy 14. ☐ Dementia/Alzheimer's Disease 15. ☐ Depression 16. ☐ Anxiety Disorder 17. ☐ Incontinence 18. ☐ Glaucoma 19. ☐ Cataracts 20. ☐ Decreased Visual Acuity 21. Additional Information

Resident Name:	Resident Number:	Effective Date:
Location:	Admission Date:	Medical Record #:
Date of Birth:	Physician:	
Allergies:		

4a.	**Medical Conditions**	
5.	**Cognitive Status**	In the last 7 days: recalls three out of four of the following; current season, that he/she is in a nursing home, location of room, staff names/faces. 1. Always 2. Sometimes 3. Never Check all that apply. 1. ☐ Impulsive 2. ☐ Impaired decision making. 3. ☐ Restless 4. ☐ Aggitation 5. ☐ Verbal Agression 6. ☐ Physical Agression 6a. ☐ Unaware of own physical abilities. 6b. ☐ Self-Transfers Contradicting Plan of Care Orientation-Check all that apply. 7. ☐ Person 8. ☐ Place 9. ☐ Time 10. ☐ Situation 11. Additional Information
6.	**Vision Pattern**	0. Adequate-able to see in adequate light with glasses on 1. Inadequate- impaired vision in adequate light with glasses on 2. Severely Impaired- no vision or sees only light, color or shape
7.	**Continence in Last 14 Days**	0. Continent: complete control 2. Occasional Incontinence: bladder 2 x/week, but not daily; bowel once a week 3. Frequently Incontinent: bladder incontinent daily, but some control present; bowel 2-3 x/week 4. Total Incontinence: daily episode of baldder incontinence; bowel always incontinent
7a.	**Pain**	1. Signs or Symptoms of Pain 1. Yes 2. No If yes, is pain a risk factor for falls? 1. Yes 2. No 2a. Explain.

Resident Name:	Resident Number:	Effective Date:
Location:	Admission Date:	Medical Record #:
Date of Birth:	Physician:	
Allergies:		

7a.	Pain	
8.	Physical Devices	A. Does the resident use a physical device? ◯ 1. Yes ◯ 2. No Select Type of Physical Device Used if Yes B1. ☐ 1/2 Side Rail* or Grab Bar * B2. ☐ Trunk Restraint * B3. ☐ Geri Chair * B4. ☐ Merry Walker * B5. ☐ Lap Buddy * B6. ☐ Hand restraint * B9. ☐ Full Rails * B10. Mobility Alarms C1. If yes, are there any safety concerns noted with it's use? ◯ 1. Yes ◯ 2. No C2. If yes, what are the safety concerns and what changes will be made to ensure safety? D1. If resident uses a physical device that restricts activity, is there an order in place? ◯ 1. Yes ◯ 2. No D2. For devices with known risk factors is there a signed consent in the chart? (these devices are identified with (*)) ◯ 1. Yes ◯ 2. No
9.	Confined to a Chair	If resident cannot walk even when assisted by staff are they: ◯ 1. Confined to a chair and oriented ◯ 3. Confined to a chair and disoriented ◯ 0. Not Applicable
10.	Blood Pressure	Drop in systolic blood pressure of 20 mmHG or more between lying and standing ◯ 2. Yes ◯ 0. No
11.	Gait Analysis	Assess a resident's gait while: standing in one spot, walking straight forward and while making a turn. 1. ☐ Unable to independently come to a standing position. 2. ☐ Exhibits loss of balance while standing. 3. ☐ Inability to maintain straight path during ambulation. 4. ☐ Requires physical assistance to transfer or ambulate.

Resident Name:	Resident Number:	Effective Date:
Location:	Admission Date:	Medical Record #:
Date of Birth:	Physician:	
Allergies:		

11.	Gait Analysis	Assess a resident's gait while: standing in one spot, walking straight forward and while making a turn. 5a. ☐ Short discontinuous steps. 5b. ☐ Changes in gait pattern while ambulating through thresholds. 5c. ☐ Shuffling Steps. 6. ☐ Lurching gait. 6a. ☐ Slapping gait. 7. ☐ Exhibits jerking or instability when making turns. 8. ☐ Utilizes assistive device during ambulation. 9. Additional Information
11a.	Environment	Choose all that apply. 1. ☐ Tubing 2. ☐ Connected to medical device (oxygen, enteral feeding, IV, etc.) 3. ☐ Environmental Clutter 4. ☐ Unclear pathways. 5. ☐ Improper footwear. 6. ☐ Environment poorly lit. 7. Additional Information
12a.	Analysis	Analysis of assessment findings/Nursing Diagnosis:
12.	Care Plan Review	1. Goal 1a. Current Interventions in Place

Resident Name:		Resident Number:		Effective Date:	
Location:		Admission Date:		Medical Record #:	
Date of Birth:		Physician:			
Allergies:					

12.	Care Plan Review	1b. History of interventions deemed ineffective. 2. Is the resident meeting their current care plan goal for safety and function? ◯ 1. Yes ◯ 2. No 3. If no, explain. 4. If no, what new interventions will be initiated after this assessment?