# Fall Report Form

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| Resident Name: | MR # |
| Physician: | Date and time: |

Person making report_____

**Resident Details:**

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|---|---|
| Mental Status:<br><br>Orientation: Person Place Time | Mobility Status:<br><br>Ambulation aid used: |
| Fall Prevention Strategies in Place at time of Fall:<br>(Fall program interventions for this resident) | What other safety measures were in place: |

**Fall Details:**

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|---|---|
| Date: | Time of Reported Fall:<br>Reported by: |
| Exact Location: | |
| What was happening at time of fall? | How did fall occur? |
| Was an injury sustained? Yes ____ No____<br>If yes please describe: | How did the injury occur? |
| Treatment required? | **VS:** T_____ P_____R_____ SpO2 _____<br><br>**B/P(upright)** _____ **B/P(supine)** _____<br><br>**Blood Glucose** (Insulin Dependent Diabetic) _____ |
| Resident statement at time of fall? | Immediate action taken: |

**Contributing Factors: List where relevant**

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|---|---|
| Medical: | Mobility: |
| Sensory Deficits: | Medications: (cardiac, antihypertensive, psychotropic) |
| Cognitive Factors: | Continence Issues: |
| Environmental Factors: | Other: |

**Immediate Interventions added to temporary care plan**

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|---|
| A: |
| B: |
| C: |

**Fall Risk Assessment and Management~~to be completed by RN Supervisor**

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|---|
| Fall Risk Assessment last conducted on: _____/_____/_____ Rating:_____ New Rating:_____<br><br>Is reassessment required?: Yes_____ No_____ If no reassessment required, specify why: |
| Current Fall Program in place: |
| New recommendations (immediate interventions) placed at time of fall appropriate for resident?:<br><br>Changes made to new interventions: |

RN Signature_____ Date_____

**Notifications**

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|---|---|
| **MD** Date_____ Time_____ | **Family** Date_____ Time_____ |