TELEPHONE VISIT - FALLS

DIRECTIONS: Obtain responses since last contact or visit.

1. Follow-up based on last fall risk assessment findings.
   Removal of safety hazards? ❑ Yes ❑ No ❑ N/A Is help needed to remove or remedy? ❑ Yes ❑ No N/A
   Describe:_____
   _____
2. Any worsening signs or symptoms of condition? ❑ Yes ❑ No If yes, describe: _____
   _____
   _____
3. Admitted to hospital for fall or injury at home? ❑ Yes ❑ No If yes, complete agency incident report.
4. ER visit for fall or injury at home? ❑ Yes ❑ No If yes, complete agency incident report.
5. Getting up to go to bathroom at night? ❑ Yes ❑ No If yes, how often? Offer remedies.
6. Unsteady on your feet, dizzy, weak, situation where you felt that you could have fallen? If yes, describe:
   _____
   _____
   Consider appropriate discipline referrals.
7. Engaging in physical activity as prescribed? ❑ Yes ❑ No
   a. If yes, describe: _____
   _____
   b. If no, describe obstacles to compliance:_____
   _____
   _____
8. Have you forgotten or missed any doses of your medication? ❑ Yes ❑ No
   Describe:_____
   _____
   Explore ways to remedy.
   a. Medication(s) causing weakness, dizziness, unsteadiness on feet, other? ❑ Yes ❑ No If yes, describe:
   _____
   _____
   b. If yes, what changes in your medications or medication schedule do <u>you think</u> would help prevent these symptoms?_____
   _____
9. Do you have questions, concerns, or comments? ❑ Yes ❑ No If yes, explain: _____
   _____
10. Remind about next physician appointment. ❑ Done

Staff Signature/Title:_____ Date:_____

PART 1 – Medical Record PART 2 - Care Coordination

PATIENT NAME – Last, First, Middle Initial	ID#