FALL REVIEW SHEET

PATIENT CARE SERVICES

Patient Name: _____ MR#: _____

Unit: _____ Date of Fall: _____

1.	Falls assessment sheet completed at time of admission?	❑ Yes	❑ No
2.	All elements of assessment complete and accurate?	❑ Yes	❑ No
3.	Reassessment(s) for fall completed in accordance with patient's changing condition?	❑ Yes	❑ No
4.	Potential for falls noted on Kardex and Patient Plan of Care?	❑ Yes	❑ No
5.	**If** patient at risk for fall, fall prevention measures implemented?	❑ Yes	❑ No
6.	Preventive measures, **if applicable**, noted on Kardex and Nurses' Notes?	❑ Yes	❑ No
7.	Patient examined by physician within 30 minutes of fall?	❑ Yes	❑ No
8.	Physician findings noted in Physician Progress Notes?	❑ Yes	❑ No
9.	Was an injury sustained during the fall?	❑ Yes	❑ No

If yes, describe: _____

_____

_____

_____

_____

10.	Could fall have been prevented?	❑ Yes	❑ No

If so, how? _____

_____

_____

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_____

Reviewer's Signature: _____ Date: _____