FALLS REPORTING SHEET

Patient Name: _____ Hospice Number: _____

Date & time of incident: _____

Location: _____

People in the vicinity at the time: _____

Circumstances surrounding the fall

Symptoms/injuries reported by the patient as a result of the fall

Any other concerns raised by the patient as a result of the fall

What were the contributory factors to the fall?

	Primary Cause (Tick one cause only)	Contributory factor (Tick any relevant factors)	Please specify more details if appropriate*
General frailty			
Agitation/confusion			
Sensory impairment			
Cardiovascular problem			
Neurological problem			
Pharmacological factors			
Environmental factors			
Inadequate supervision			
Other			

* Please document detailed information in the clinical notes if appropriate.

Baseline observations (Only taken as appropriate)

	Result
Temperature	
BM	
Urine dip test	
MMSE	
Six point score	

Other clinical findings (including medical assessment)*

Is there any evidence of head injury? Yes / No
Are there any lacerations? Yes / No
Is there any evidence of fractures? Yes / No

What investigations/treatment need to be taken for this patient as a result of this fall?*
What, if anything, can be done to reduce the risk of future falls in this patient?*
What, if anything, can be done to reduce the risk of future falls of this nature within the organisation?*

Nurse's signature: Date & Time

Doctor's Signature Date & Time

Nurse in Charge's Signature Date & Time

Senior Nurse's Signature Date & Time

* Please document detailed information in the clinical notes if appropriate.