Form No: 03-3-019 **HIGH RISK OF FALLS - *SERVICE USER***

CARE PLAN GUIDANCE CHECKLIST

A: DETAILS					
Surname:		First Name(s):		Title:	
Age last birthday:		Date of Birth:		Place of Birth:	
HEIGHT:		WEIGHT:		**HISTORY OF FALLS**	YES / NO

B: FALLS SCREENING CHECKLIST	
If the answer to any of the questions B.1 to B.4 below is YES, proceed to Part C of this Form: *Care Plan Guidance Checklist*	
B.1 Has the service user had a fall within the past 6 months?	YES / NO
B.2 Does the service user try to walk alone, but appears to be unsteady or unsafe?	YES / NO
B.3 Does the service user use walking aids?	YES / NO
B.4 Is the service user or relative anxious about falls?	YES / NO

C: CARE PLAN GUIDANCE CHECKLIST		
Is the service user having problems with, or at risk of:	YES / NO	If "YES", follow the interventions applicable to this service user and record details. The Care Plan should reflect and address identified issues.
Gait, balance, mobility and /or muscle weakness?		Refer to physiotherapist for treatment regime. Refer to GP for assessment.
Perceived functional ability, and / or fears relating to falling?		Refer to Occupational Therapist for treatment regime. Support service user when walking.
Visual impairment?		Refer to optician / ophthalmologist for treatment regime.
Cognitive impairment and / or neurological impairment?		Ensure Care Plan promotes mental well-being. Support with daily living activities (orientation etc).
Urinary incontinence?		Ensure continence Care Plan in place. Review medication regime.
Nutritional fluid intake?		Monitor dietary and fluid intake. Provide support with eating and drinking.
Environmental hazards; e.g. poorly-fitting footwear, inappropriate use of walking aids, home hazards?		Advice from physiotherapist on correct use of walking aids. Refer to Occupational Therapist for full home assessment.
Medication likely to cause risk of falls?		Review medication regime with community pharmacist. Review medication regime with specialist medical team.