ASSESS

☐ **Recent Fall**
(last 3 months)

☐ **Impaired Gait**
- ☐ Mobility aid use
- ☐ Sensorimotor deficits
- ☐ Neurological deficits

☐ **Mental Status**
- ☐ Confused
- ☐ Disoriented
- ☐ Intoxicated
- ☐ Sedated

☐ **NO RISK IDENTIFIED**

IMPLEMENT appropriate fall prevention interventions.

- ☐ Purple ID band
- ☐ Skid-proof slippers
- ☐ Fall flag on WB
- ☐ Bed in low position
- ☐ Close to nursing station
- ☐ Sign on curtain
- ☐ Other *(indicate under "Document" or clinical notes)*

DOCUMENT clinical assessment

DATE/TIME: _____ **RN SIGNATURE**: _____