Name_____ Date_____

Cabell Huntington Hospital

Fall Risk Assessment Tool

Please complete and return to the medical or surgical assistant.

Edwards Comprehensive Cancer Center

RISK FACTOR	CIRCLE ONE	SCORE	NOTES
1. Do you wear glasses, bifocals or a hearing aid?	Yes No	1	
2. Have you fallen in the last year?	Yes No	4	
3. In the last year, have you had a broken bone or been diagnosed with osteoporosis?	Yes No	2	
4. Do you use a cane, walker or wheelchair?	Yes No	2	
5. Do you have problems with dizziness, fainting or seizures?	Yes No	3	
6. Do you ever need help getting up from a chair?	Yes No	3	
7. Are you unsteady on your feet?	Yes No	3	
8. Do you have trouble with neuropathy, numbness, tingling, swelling or weakness in your feet or legs?	Yes No	3	
9. In the last 24 hours, did you take a laxative or diuretic (water pill) or any medication for pain, anxiety, high blood pressure or sleep?	Yes No	2	
10. Do you have any problems with diarrhea or urinary urgency?	Yes No	2	

Based on Cabell Huntington Hospital's Fall Risk Assessment and Memorial Sloan-Kettering Cancer Center's Patient Falls Risk Assessment.

NOTES: Total Score _____ Additional comments: _____

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Notes made by _____