Client: ....

Date: ....

QUICKSCREEN© Clinical Falls Risk Assessment Form

For the following risk factors score **'YES'** if risk factor is present. Score **'NO'** if risk factor is not present.

MEASURE	RISK FACTOR PRESENT? (please circle)	ACTION / COMMENTS

Previous Falls

One or more in previous year	**YES / NO**	

Recommendation: Possible referral for Home Hazards Assessment from Occupational Therapist

Medications

Four or more (excluding vitamins)	**YES / NO**	
Any psychotropic	**YES / NO**	

Recommendation: Refer to GP for Medications Review

Vision

Low contrast visual acuity test Unable to see all of line 3 (16mm)	**YES / NO**	

Recommendation: Refer to optometrist

Peripheral Sensation

Tactile sensitivity test Unable to feel 2 out of 3 trials	**YES / NO**	

Recommendation: Refer to relevant health professional (Diabetes Nurse, Podiatrist etc.)

Strength / Reaction Time / Balance

Near tandem stand test (eyes closed) Unable to stand for 10secs	**YES / NO**	
Alternate step test (4 each side) Unable to complete in 15secs	**YES / NO**	
Sit to stand test (5 times) Unable to complete in 15secs	**YES / NO**	

Recommendation: Refer to Physiotherapist / Exercise Physiologist

Number of risk factors	**0**	**1**	**2**	**3**	**4**	**5+**
Total risk increase	**1**	**1.4**	**2.1**	**4.7**	**8.7**	**12**

Total Risk Increase: The client has____________ times the risk of falling as someone with no risk factors.

Health Professional: ....

Adapted with permission from Prince of Wales Medical Research Institute

Signed: ....