

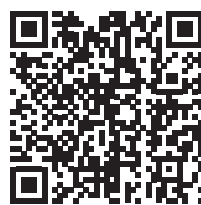
Patient Details

Medical Post Fall Review - (file in patient notes)

Please scan QR codes for further guidance.



Falls Guidelines



Head Injury
Guideline



Head injury with
coagulopathy



Suspected
Spinal injury

What happened, with as much detail as possible e.g. - circumstances of the fall - include time/date of fall and location e.g. bed space	Cause of fall? Tick all applicable boxes		Actions to reduce falls risk: Tick all applicable boxes	
	Impaired balance? (e.g. CVD, MSK disorder, neuropathy, movement disorder)		L+S BP	
	Transient loss of consciousness? (e.g. postural hypotension, arrhythmia, aortic stenosis, seizure?)		ECG	
	Cognitive impairment? (e.g. delirium, dementia)		Delirium screen	
	Medication? (e.g. sedatives, anti-hypertensives, antipsychotics)		Medication Review	
	Environment? (e.g. hazard, poor footwear, spectacles not worn)		Increased supervision/ observation	
	Other (describe)		Other (describe)	

Examination Findings

	Pre fall	Post fall	Head injury should be considered if person: Is aged 65 or over, has coagulopathy, sustained a fall from > 1 m or 5 stairs, shows signs of obvious head injury. See head injury guidance/proforma for further support.	Description of injury		
GCS						
4AT						
NEWS						
Potential Head injury	Yes	No				
Was the fall unwitnessed?						
Did they hit their head?						
Any visible head injuries?						
Any head pain reported or suspected?						
Neurological examination normal?						
Are they on anticoagulants?						
Spine	Yes	No	If concerned of spinal injury then patient should be immobilised and refer to spinal injury guidance			
Did they strike their spine/neck?						
Spinal tenderness?						
New Neuro symptoms?bladder or bowel function/loss of sensation/muscle weakness						
Neurological examination normal?						
Upper limbs	Yes	No				
Pain reported or suspected?						
Tenderness/deformity?						
Reduced ROM?						
Lower limbs	Yes	No				
Pain reported or suspected esp in groin or palpation of lateral aspect of thigh?						
Shortening/external rotationof hip?						
Able to straight leg raise?						
Change in mobility/function since fall?						

Medical review completed by:

Signature:	Print Name:	Designation:	Date:	Time:
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