CHECKLIST

Fall Risk Factors

Patient _____

Date _____

Time _____ ☐ AM ☐ PM

Fall Risk Factor Identified	Present?		Notes
FALLS HISTORY			
Any falls in past year?	☐ Yes	☐ No	
Worries about falling or feels unsteady when standing or walking?	☐ Yes	☐ No	
MEDICAL CONDITIONS			
Problems with heart rate and/or arrhythmia	☐ Yes	☐ No	
Cognitive impairment	☐ Yes	☐ No	
Incontinence	☐ Yes	☐ No	
Depression	☐ Yes	☐ No	
Foot problems	☐ Yes	☐ No	
Other medical problems	☐ Yes	☐ No	
MEDICATIONS (PRESCRIPTIONS, OTCs, SUPPLEMENTS)			
Psychoactive medications	☐ Yes	☐ No	
Opioids	☐ Yes	☐ No	
Medications that can cause sedation or confusion	☐ Yes	☐ No	
Medications that can cause hypotension	☐ Yes	☐ No	
GAIT, STRENGTH & BALANCE			
Timed Up and Go (TUG) Test ≥12 seconds	☐ Yes	☐ No	
30-Second Chair Stand Test: Below average score based on age and gender	☐ Yes	☐ No	
4-Stage Balance Test: Full tandem stance <10 seconds	☐ Yes	☐ No	
VISION			
Acuity <20/40 OR no eye exam in >1 year	☐ Yes	☐ No	
POSTURAL HYPOTENSION			
A decrease in systolic BP ≥20 mm Hg, or a diastolic BP of ≥10 mm Hg, or lightheadedness, or dizziness from lying to standing	☐ Yes	☐ No	
OTHER RISK FACTORS (SPECIFY BELOW)			
	☐ Yes	☐ No	

Centers for Disease Control and Prevention
National Center for Injury Prevention and Control

STEADI Stopping Elderly Accidents, Deaths & Injuries

2017

REFERRAL FORM

Fall Prevention Patient Referral

PATIENT INFORMATION

Patient:	**Referred to:** FYZICAL Therapy & Balance Centers Prairieville
Sex: ☐ Male ☐ Female **DOB:** / /	
Address:	**Address:** 16172 Airline Hwy Suite B Prairieville, LA 70769 Next to Acadiana Optical
Phone:	**Phone:** (225) 255-4020 FAX (225) 255-4024
Email:	**Email:** prairieville@fyzical.com
Diagnosis:	

PT to evaluate and treat: ☐

TYPE OF REFERRAL

Type of specialist:

Exercise or fall prevention program:

Additional recommendations:

REASON FOR REFERRAL

☐ Gait or mobility problems	☐ Medication review & consultation
☐ Balance difficulties	☐ Inadequate or improper footwear
☐ Lower body weakness	☐ Foot abnormalities
☐ Postural hypotension	☐ Vision <20/40 in ☐ Right ☐ Left ☐ Both
☐ Suspected neurological condition (e.g., Parkinson's disease, dementia)	☐ Home safety evaluation led by occupational therapist

Other reason:

Other relevant information:

Referrer signature: _____ **Date:** _____

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