



Falls: Fall Investigation Report 2

Resident name: _____ Room #: _____

M F DOB: _____ Age: _____

Medical record #: _____ Date of incident: _____ Time of incident: _____ AM PM

Vital signs after incident: BP: _____ R: _____ T: _____ Oral/Axillary/Ear

Witness: No Yes (Name) _____

Severity Level (Highest level of injury)		
<input type="checkbox"/> No injury	<input type="checkbox"/> Minor injury/First Aid only (e.g., bruise, abrasion, skin tear)	<input type="checkbox"/> Major injury, resident to hospital (e.g., laceration w/suture, closed head injury, fracture)
<input type="checkbox"/> Death		
Treatment (Check all that apply.)		
<input type="checkbox"/> To PCP for evaluation	<input type="checkbox"/> To emergency room	<input type="checkbox"/> Admit to hospital
<input type="checkbox"/> Sutures	<input type="checkbox"/> X-ray	<input type="checkbox"/> Bloodwork
<input type="checkbox"/> Urinalysis	<input type="checkbox"/> Other: _____	
Location		
<input type="checkbox"/> Resident's room	<input type="checkbox"/> Resident's bathroom	<input type="checkbox"/> Another resident room/bathroom
<input type="checkbox"/> Hallway	<input type="checkbox"/> Dining room/day room	<input type="checkbox"/> Shower room
<input type="checkbox"/> Outside building	<input type="checkbox"/> Other: _____	
1. Was the incident a:		
<input type="checkbox"/> Found on floor (unwitnessed)	<input type="checkbox"/> Fall to floor (witnessed)	<input type="checkbox"/> Near fall (resident lowered to floor or stabilized by staff/other)
<input type="checkbox"/> Self-reported fall		
2. The cause of the incident was:		
<input type="checkbox"/> Lost balance	<input type="checkbox"/> Lost strength/weakness	<input type="checkbox"/> Tripped
<input type="checkbox"/> Lost consciousness/seizure	<input type="checkbox"/> Slipped, specify: _____	
<input type="checkbox"/> Environmental malfunction, specify: _____		
<input type="checkbox"/> Environmental factor (i.e., clutter, inadequate lighting, floor), specify: _____		
<input type="checkbox"/> Other, specify: _____		
3. Activity during the incident was:		
<input type="checkbox"/> Ambulation in bedroom	<input type="checkbox"/> Ambulating to/from bathroom	<input type="checkbox"/> Transferring on/off toilet
<input type="checkbox"/> Ambulation in hallway	<input type="checkbox"/> Sliding out of wheelchair	<input type="checkbox"/> Changing clothes/other ADLs
<input type="checkbox"/> Getting up from chair/wheelchair Brakes locked? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Getting in/out of tub or shower	
<input type="checkbox"/> Getting in/out of bed Bed wheels locked? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Reaching for something	
<input type="checkbox"/> Low to floor bed with pad <input type="checkbox"/> Yes <input type="checkbox"/> No		
<input type="checkbox"/> Other, specify: _____		

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4. Footwear at the time of the incident was:		
<input type="checkbox"/> Shoes	<input type="checkbox"/> Slippers	<input type="checkbox"/> Socks (plain)
<input type="checkbox"/> Nonskid socks	<input type="checkbox"/> Bare feet	<input type="checkbox"/> Other: _____
5. Was there staff present during this activity?		
<input type="checkbox"/> Yes	<input type="checkbox"/> No	
6. Indicate aid in use at time of incident:		
<input type="checkbox"/> None	<input type="checkbox"/> Cane	<input type="checkbox"/> Wheelchair
<input type="checkbox"/> Walker	<input type="checkbox"/> Merry walker	<input type="checkbox"/> Hip protectors
<input type="checkbox"/> Other, specify: _____		
7. Was a restraint in use at the time of the incident?		
<input type="checkbox"/> Yes	<input type="checkbox"/> No	
<input type="checkbox"/> Seat belt/roll belt/waist restraint	<input type="checkbox"/> Lap buddy/tray	<input type="checkbox"/> Wrist/hand mitten
<input type="checkbox"/> Gerichair with table	<input type="checkbox"/> Other, specify: _____	
8. Were the side rails up?		
<input type="checkbox"/> Yes	<input type="checkbox"/> No	
<input type="checkbox"/> Partial rails	<input type="checkbox"/> Full rails (2 full or 4 half rails on both sides)	
9. Was alarm present?		
<input type="checkbox"/> Yes	<input type="checkbox"/> No	
<input type="checkbox"/> Bed alarm did not sound during event	<input type="checkbox"/> Chair alarm sounded during event	<input type="checkbox"/> Chair alarm did not sound during event
<input type="checkbox"/> Other, specify: _____		
As a result of this incident:		
10. Did the resident's mental status change?		
<input type="checkbox"/> Yes	<input type="checkbox"/> No	
11. Did the resident's level of consciousness change?		
<input type="checkbox"/> Yes	<input type="checkbox"/> No	

Physician name: _____ Time notified: _____ AM PM Date notified: _____ Fax Phone

Family/POA notified (name): _____ Date notified: _____ Time notified: _____ AM PM

Nurse signature: _____ Title: _____ Date: _____ Time: _____ AM PM

Director of Nursing signature: _____ Date: _____

Administrator signature: _____ Date: _____

Medical Director signature: _____ Date: _____

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Indicate site(s) injured and type of injury

Injury Site			Type of Injury				
	Left or Right		Bruise, skin tear, or abrasion, laceration without suture	Fracture	Laceration with suture or closed head injury	Pain	Other, specify type of injury
Head	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____
Neck	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____
Spine, lower	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____
Spine, upper	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____
Shoulder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____
Arm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____
Wrist	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____
Chest	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____
Abdomen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____
Pelvis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____
Hip	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____
Leg	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____
Ankle	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____
Foot	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____
Other site	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____
Other site, specify: _____							

If necessary, please provide a brief narrative of this incident: _____
