

Fall Prevention Assisted Home Safety Assessment

1. Explain to client the reason for the visit
 - Identify things in the home that may cause a fall
 - Reduce risk of falling
2. Discuss their falls history
 - Have they fallen?
 - Anything in the house that worries them?
3. Education part 1
 - Fear of falling increases risk
 - Falls are the leading cause of death in adults over age 65
 - Falls can be prevented
4. Explain outcomes of the visit
 - 1-2 hour visit
 - Recognize the common risk factors
 - Identify strategies to reduce risk of falling
5. Do pre-test with client
6. Education part 2
 - Falls may be...
 - A sign of a health problem (irregular heart beat)
 - Progression of a chronic condition (Parkinson's)
 - Due to changes in medication- some medications have side effects that make you feel dizzy and cause you to lose your balance or feel unsteady. Talk to your doctor about medication and possible side effects for falling.
 - Onset of age-related changes

Developed by Kalpana N Shankar MD; Jennifer Kaldenberg MSA, OTR/L; Anne Escher MS, OTR/L for the Boston Public Health Commission Prevention and Wellness Trust Program and adapted by Julie St. John DrPH, MA, CHWI in partnership and with funding provided by Massachusetts Department of Public Health Prevention and Wellness Trust Fund.

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- An accident

Falls are due to physical, behavioral and environmental risk (explain each)

Example

Older woman stands on a chair and tries to reach a jar off of the top shelf of the pantry, what could be some risk factors in this example?

Have client answer and talk about what category each risk falls into.

Instructions: Check for risks in the following places by answering **No** or **Yes** to the question. If the answer is **Yes**, consider the recommendation to address the risk and reduce the likelihood of falling.

Unique Identifier #:	
Date of Home Assessment: MM/DD/YYYY	
Referring Entity:	
Primary Care Physician:	
First Name:	
Last Name:	
Address:	
APT/SUITE#	
City:	
Zip Code:	

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Telephone:	
Mobile:	
Secondary Contact (name):	
Secondary Contact (phone number):	
Secondary Contact (relationship):	
Date of Birth: MM/DD/YYYY	

Housing Status

- Own
- Rent
- Public Housing
- Subsidized Housing
- Other

Living Arrangements

- Alone
- Spouse
- Single Parent- Living with Child
- Two Adults- Living with Child
- Other

Gender

- Male
- Female
- Transgender

Ethnicity/Race (please select all that apply)



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Hispanic/Latino AND

- American Indian/Alaska Native
- Asian
- Black/African American
- More than One Race
- Native Hawaiian
- Other Pacific Islander
- White
- Unreported/Refused to Report

Non-Hispanic/Latino AND

- American Indian/Alaska Native
- Asian
- Black/African American
- More than One Race
- Native Hawaiian
- Other Pacific Islander
- White
- Unreported/Refused to Report
- Unreported/Refused to Report both Race and Ethnicity

Preferred Language

- English
- Spanish
- Portuguese
- Chinese- Mandarin
- Vietnamese
- Haitian Creole
- Cape Verdean Creole

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Other _____ [make a text field]

Supplemental Questions		
Does client have feelings of loneliness or being isolated? <input type="checkbox"/> Yes <input type="checkbox"/> No Notes:	<input type="checkbox"/> PCP Referral to a Clinical Specialist	<input type="checkbox"/> ASAP/AAA
Is client taking medication as prescribed by their PCP? <input type="checkbox"/> Yes <input type="checkbox"/> No Notes:	<input type="checkbox"/> PCP Referral to a Clinical Specialist	<input type="checkbox"/> ASAP/AAA
Does the client feel safe at home? [PERS] <input type="checkbox"/> Yes <input type="checkbox"/> No Notes:	<input type="checkbox"/> ASAP/AAA	
Does the client need help resolving issues with landlord? <input type="checkbox"/> Yes <input type="checkbox"/> No Notes:	<input type="checkbox"/> ASAP/AAA	

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Is the heat/AC in the client's home functioning? <input type="checkbox"/> Yes <input type="checkbox"/> No Notes:	<input type="checkbox"/> ASAP/AAA/ISD		
Are there cockroaches/ants or any other pests or rodents in the home? <input type="checkbox"/> Yes <input type="checkbox"/> No Notes:	<input type="checkbox"/> Client/Landlord	<input type="checkbox"/> PCP Referral to a Clinical Specialist	<input type="checkbox"/> ISD
Are there enough healthy foods in the home? <input type="checkbox"/> Yes <input type="checkbox"/> No Notes:	<input type="checkbox"/> ASAP/AAA		
Does client have access to transportation? (bus, car, elderly transportation etc.) <input type="checkbox"/> Yes <input type="checkbox"/> No Notes:	<input type="checkbox"/> ASAP/AAA		

FLOORS/WALKWAYS: Look at the floor in each room.			
HAZARD	RECOMMENDATION	Modification Completed?	Follow-up required?

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<i>Education:</i>	<i>Notice the floors: tile or marble floors are slippery when they're wet; deep pile carpet and transitions between rooms can be a tripping hazard.</i>			
When you walk through a room, do you have to walk around furniture? <input type="checkbox"/> Yes <input type="checkbox"/> No Notes:	<input type="checkbox"/> Client. <i>Remove clutter or furniture that prevents easy movement. Rearrange or donate items not needed or used.</i>	<input type="checkbox"/> ASAP/AAA		
Are there throw rugs on the floor/ <input type="checkbox"/> Yes <input type="checkbox"/> No Notes:	<input type="checkbox"/> Client. <i>Remove rugs or use double-sided tape or non-slip backing to prevent slipping.</i>	<input type="checkbox"/> ASAP/AAA		
Are there papers, books, towels, shoes magazines, boxes, blankets or other objects on the floor? <input type="checkbox"/> Yes <input type="checkbox"/> No Notes:	<input type="checkbox"/> Client. <i>Pick up items on the floor. Always keep objects off the floor that might cause a fall.</i>	<input type="checkbox"/> ASAP/AAA		

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Do you have to walk over or around wires or cords (like lamp, telephone or extension cords?) <input type="checkbox"/> Yes <input type="checkbox"/> No Notes:	<input type="checkbox"/> Client. <i>Coil or tape cords and wires next to the wall so no one can trip over them. If needed, have an electrician put in another outlet.</i>	<input type="checkbox"/> ASAP/AAA	
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_____ Total # of floor hazards present	Total # of recommendations _____ Client/landlord _____ ASAP/AAA
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LIVING ROOM. Look around the entire room for items that might cause a person to fall.

HAZARD	RECOMMENDATION	Modification Completed?	Follow-up required?
Education	<ul style="list-style-type: none"> Make sure outlets are in good, working condition and not overloaded with cords Remove throw rugs or use double sided tape to keep the rugs from slipping All exits should be unblocked and accessible 		
Poor lighting? <input type="checkbox"/> Yes <input type="checkbox"/> No Notes:	<input type="checkbox"/> Client. <i>Increase wattage to allowable limits in lamps/lights. Add lamps or wall/overhead lights.</i>	<input type="checkbox"/> ASAP/AAA	

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Unstable furniture? <input type="checkbox"/> Yes <input type="checkbox"/> No Notes:	<input type="checkbox"/> Client. <i>Place a block under the shorter leg. Repair or replace broken furniture.</i>	<input type="checkbox"/> ASAP/AAA		
Difficulty accessing light switches? Client can NOT easily turn lights on/off? <input type="checkbox"/> Yes <input type="checkbox"/> No Notes:	<input type="checkbox"/> Client. <i>Add "clapper" light switch control to lamps. There are other remote control switching options for operating the lights. Move wall switches. Rearrange furnishings to allow quick access to wall switch or lamps.</i>	<input type="checkbox"/> ASAP/AAA		
Client does NOT have a lamp(s) nearby main seating area? <input type="checkbox"/> Yes <input type="checkbox"/> No Notes:	<input type="checkbox"/> Client. <i>Add lamp for more light.</i>	<input type="checkbox"/> ASAP/AAA		

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Seating does NOT have firm seat or arm rests on both sides (for chairs) &/or is too low or deep? (ask client if they can sit and evaluate whether their legs in the seated position are at a 90 degree angle) <input type="checkbox"/> Yes <input type="checkbox"/> No Notes:	<input type="checkbox"/> Client. <i>If the chair is too low, add a leg riser. A chair that is too high or without arms should not be used, as it will not provide sufficient stability to get in & out of chair.</i>	<input type="checkbox"/> ASAP/AAA		
If wheelchair is used, it does NOT have a pressure relief seat cushion (not patient's own seat pillow)? <input type="checkbox"/> Yes <input type="checkbox"/> No Notes:	<input type="checkbox"/> Client. <i>Get a pressure relief seat cushion.</i>	<input type="checkbox"/> ASAP/AA A	<input type="checkbox"/> N/A	
Flooring has rips and holes? <input type="checkbox"/> Yes <input type="checkbox"/> No Notes:	<input type="checkbox"/> Client/Landlord	<input type="checkbox"/> BHA	<input type="checkbox"/> ASAP /AAA	

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Client has difficulty opening/ closing at least one window & all blinds or shades? <input type="checkbox"/> Yes <input type="checkbox"/> No Notes:	<input type="checkbox"/> Client/Landlord. <i>Have friend or family member check winders. Replace blinds/shades.</i>	<input type="checkbox"/> BHA	<input type="checkbox"/> ASAP/AAA		
_____ Total # of living room hazards present	<i>Total # of recommendations</i> _____ Client _____ ASAP/AAA _____ BHA				

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HALLWAYS: Check for hazards in all the hallways in the home.					
HAZARD	RECOMMENDATION			Modification Completed?	Follow-up required?
Dark or poor lighting? Lack of access to ceiling light? <input type="checkbox"/> Yes <input type="checkbox"/> No Notes:	<input type="checkbox"/> Client/Landlord. <i>Increase wattage of bulbs to allowable level. Add additional overhead lighting.</i>	<input type="checkbox"/> BHA	<input type="checkbox"/> ASAP/AAA		
Uneven or slippery flooring? <input type="checkbox"/> Yes <input type="checkbox"/> No Notes:	<input type="checkbox"/> Client/Landlord. <i>Do not walk on a wet floor. Wear comfortable shoes or socks with a non-skid sole. Change flooring to one that is less slippery.</i>	<input type="checkbox"/> BHA	<input type="checkbox"/> ASAP/AAA		
Lack of access to ceiling light? <input type="checkbox"/> Yes <input type="checkbox"/> No Notes:	<input type="checkbox"/> Client/Landlord	<input type="checkbox"/> BHA	<input type="checkbox"/> ASAP/AAA		

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Hallways have clutter or flooring contains rips & holes? <input type="checkbox"/> Yes <input type="checkbox"/> No Notes:	<input type="checkbox"/> Client/Landlord. <i>Pick up clutter. Fix or replace flooring.</i>	<input type="checkbox"/> BHA	<input type="checkbox"/> ASAP/AAA			
Area rug isn't attached to floor with double-sided tape or non-skid pad? <input type="checkbox"/> Yes <input type="checkbox"/> No Notes:	<input type="checkbox"/> Client. <i>Remove rugs or use double-sided tape or non-slip backing to prevent slipping.</i>					
_____ Total # of hallway hazards present	Total # of recommendations _____ Client/landlord _____ BHA _____ ASAP/AAA					
LAUNDRY/BASEMENT: Look at the laundry room and/or basement.						
HAZARD	RECOMMENDATION			Modification Completed?	Follow-up required?	
Difficulty accessing the laundry? <input type="checkbox"/> Yes <input type="checkbox"/> No Notes:	<input type="checkbox"/> Client. <i>Add railings. Eliminate clutter. Increase wattage or add additional lighting. Add non-slip treads to stairs.</i>			<input type="checkbox"/> ASAP/AAA		

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Difficulty accessing the basement? <input type="checkbox"/> Yes <input type="checkbox"/> No Notes:	<input type="checkbox"/> Client. <i>Add railings. Eliminate clutter. Increase wattage or add additional lighting. Add non-slip treads to stairs.</i>	<input type="checkbox"/> ASAP/AAA		
Items on the floors/counters? <input type="checkbox"/> Yes <input type="checkbox"/> No Notes:	<input type="checkbox"/> Client. <i>Pick up clutter and put or throw away.</i>			
_____ Total # of hazards present in the laundry room and/or basement	Total # of recommendations _____ Client/landlord _____ ASAP/AAA			

KITCHEN: Look at your kitchen and eating area.			
HAZARD	RECOMMENDATION	Modification Completed?	Follow-up required?
Education	<ul style="list-style-type: none"> Keep emergency numbers (in large print) near each phone Keep items you use often in cabinets you can reach easily without using a step stool The stove should be free of grease with no objects sitting on top of it The refrigerator should be working properly Use skid-proof kitchen mats on the floor Take the trash out on a regular basis and don't let it pile up 		

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<p>Not enough counter space?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Notes:</p>	<p><input type="checkbox"/> Client. <i>Clear counter space of clutter. Use a Lazy Susan. Move kitchen table closer to counter for additional work space. Use a rolling cart for added work space.</i></p>	<p><input type="checkbox"/> ASAP/AAA</p>	
<p>Using a stool or a chair to reach things?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Notes:</p>	<p><input type="checkbox"/> Client. <i>Get help to move items in to lower cabinets. Keep things used often on the lower shelves (about waist level). If you must use a step stool, get one with a bar to hold on to. Never use a chair as a step stool.</i></p>	<p><input type="checkbox"/> ASAP/AAA</p>	
<p>Not enough room to maneuver?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Notes:</p>	<p><input type="checkbox"/> Client. <i>Ask a friend or family member to remove excessive furniture. Clear clutter. Remove a leaf from the table & push table closer to the wall.</i></p>	<p><input type="checkbox"/> ASAP/AAA</p>	
<p>Presence of throw/scatter rug?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Notes:</p>	<p><input type="checkbox"/> Client. <i>Remove rugs or use double-sided tape or non-slip backing to prevent slipping.</i></p>	<p><input type="checkbox"/> ASAP/AAA</p>	

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Presence of slippery floor? <input type="checkbox"/> Yes <input type="checkbox"/> No Notes:	<input type="checkbox"/> Client. <i>Put a non-slip rubber mat on the floor.</i>	<input type="checkbox"/> ASAP/AAA		
Poor lighting? <input type="checkbox"/> Yes <input type="checkbox"/> No Notes:	<input type="checkbox"/> Client/Landlord. <i>Have a friend or family member put in a brighter light bulb or have an electrician install additional lighting.</i>	<input type="checkbox"/> BHA	<input type="checkbox"/> ASAP/AAA	
Presence of a pet underfoot when preparing meals? <input type="checkbox"/> Yes <input type="checkbox"/> No Notes:	<input type="checkbox"/> Client/Landlord			
Is there difficulty accessing sink & food preparation areas? <input type="checkbox"/> Yes <input type="checkbox"/> No Notes:	<input type="checkbox"/> PCP Referral to clinical specialist	<input type="checkbox"/> ASAP/AAA		

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Client has difficulty accessing needed food & supplies? <input type="checkbox"/> Yes <input type="checkbox"/> No Notes:	<input type="checkbox"/> PCP Referral to clinical specialist	<input type="checkbox"/> ASAP/AAA	
Client has difficulty transferring food from kitchen to table? <input type="checkbox"/> Yes <input type="checkbox"/> No Notes:	<input type="checkbox"/> PCP Referral to clinical specialist	<input type="checkbox"/> ASAP/AAA	
_____ Total # of kitchen hazards present	Total # of recommendations _____ Client/landlord _____ BHA _____ ASAP/AAA _____ PCP Referral to clinical specialist		
STAIRWAYS: Look at the stairs both inside and outside the home.			
HAZARD	RECOMMENDATION	Modification Completed?	Follow-up required?
Education	<ul style="list-style-type: none"> All exits should be unblocked and accessible Paint a contrasting color on the top edge of all steps so you can see the stairs better. For example, use light color paint on dark wood Install handrails and lights on all staircases Remove things you can trip over from stairs 		

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<p>Are there papers, shoes, books or other objects on the stairs?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Notes:</p>	<p><input type="checkbox"/> Client. <i>Pick up things on the stairs; keep objects off stairs.</i></p>	<p><input type="checkbox"/> ASAP/AAA</p>	
<p>Slippery stairwell?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Notes:</p>	<p><input type="checkbox"/> Client. <i>Attach non-slip rubber treads to the stairs.</i></p>	<p><input type="checkbox"/> ASAP/AAA</p>	
<p>Is a light missing over the stairway?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Notes:</p>	<p><input type="checkbox"/> Client. <i>Have an electrician put in an over-head light at the top and bottom of the stairs.</i></p>	<p><input type="checkbox"/> ASAP/AAA</p>	
<p>Is stairway light bulb burned out?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Notes:</p>	<p><input type="checkbox"/> Client. <i>Have a friend or family member change light bulb.</i></p>	<p><input type="checkbox"/> ASAP/AAA</p>	

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Client's last name: _____

Fall Prevention Assisted Home Safety Assessment

<p>Is there only one light switch for the stairs (only at the top or at the bottom of the stairs)?</p> <p style="margin-left: 20px;"> <input type="checkbox"/> Yes <input type="checkbox"/> No </p> <p>Notes:</p>	<p><input type="checkbox"/> Client/Landlord. <i>Have an electrician put in a light switch at the top and bottom of stairs. Option: get light switches that glow.</i></p>	<p><input type="checkbox"/> BHA</p>	<p><input type="checkbox"/> ASAP/AAA</p>		
<p>Is the carpet on the steps loose or torn?</p> <p style="margin-left: 20px;"> <input type="checkbox"/> Yes <input type="checkbox"/> No </p> <p>Notes:</p>	<p><input type="checkbox"/> Client/Landlord. <i>Firmly attach flooring to each step or remove carpet & attach non-slip rubber treads to the stairs.</i></p>	<p><input type="checkbox"/> BHA</p>	<p><input type="checkbox"/> ASAP/AAA</p>		
<p>Are the handrails loose or broken? Is there a handrail on only one side of the stairs?</p> <p style="margin-left: 20px;"> <input type="checkbox"/> Yes <input type="checkbox"/> No </p> <p>Notes:</p>	<p><input type="checkbox"/> Client/Landlord. <i>Fix loose handrails or put in new ones. Make sure handrails are on both sides of the stairs and are as long as the stairs.</i></p>	<p><input type="checkbox"/> BHA</p>	<p><input type="checkbox"/> ASAP/AAA</p>		

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Client's last name: _____

Fall Prevention Assisted Home Safety Assessment

Edges of steps and landing are not clearly visible? <input type="checkbox"/> Yes <input type="checkbox"/> No Notes:	<input type="checkbox"/> Client/Landlord. <i>Paint edges of steps a dark, visible color.</i>	<input type="checkbox"/> BHA	<input type="checkbox"/> ASAP/AAA		
Client has difficulty managing the stairs <input type="checkbox"/> Yes <input type="checkbox"/> No Notes:	<input type="checkbox"/> PCP Referral to clinical specialist		<input type="checkbox"/> ASAP/AAA		
_____ Total # of hazards present in stairways	Total # of recommendations _____ Client/landlord _____ BHA _____ ASAP/AAA _____ PCP Referral to clinical specialist				

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Client's last name: _____

Fall Prevention Assisted Home Safety Assessment

BEDROOMS: Look in all the bedrooms in the home.

Education	<ul style="list-style-type: none"> Put a phone near the floor in case you fall and cannot get up Think about wearing an alarm device that will bring help in case you fall and can't get up 		
HAZARD	RECOMMENDATION	Modification Completed?	Follow-up required?
Light near the bed is NOT easy to reach? <input type="checkbox"/> Yes <input type="checkbox"/> No Notes:	<input type="checkbox"/> Client/Landlord	<input type="checkbox"/> ASAP/AAA	
Path from your bed to the bathroom is NOT well lit? <input type="checkbox"/> Yes <input type="checkbox"/> No Notes:	<input type="checkbox"/> Client. <i>Place a lamp close to the bed where it's easy to reach.</i>	<input type="checkbox"/> ASAP/AAA	
Items are not easy to reach (TV remote, lamp)? <input type="checkbox"/> Yes <input type="checkbox"/> No Notes:	<input type="checkbox"/> Client. <i>Ask a friend or family member to move items within easy reach.</i>	<input type="checkbox"/> ASAP/AAA	

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Client's last name: _____

Fall Prevention Assisted Home Safety Assessment

<p>Bedcovering cover the floor?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Notes:</p>	<p><input type="checkbox"/> Client. <i>Replace bedcovering so it doesn't touch floor.</i></p>	<p><input type="checkbox"/> ASAP/AAA</p>	
<p>Hospital bed only: There are large spaces between mattress & side rails (could roll into space)?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Notes:</p>	<p><input type="checkbox"/> Client. <i>Get help to reduce the space between mattress & side rails (place rolled up blanket, sheet, foam, etc.).</i></p>	<p><input type="checkbox"/> ASAP/AAA</p>	<p><input type="checkbox"/> N/A</p>
<p>Mattress is NOT supportive & sags when sat on? (ask the client to sit on the bed and evaluate whether their legs in the seated position are at a 90 degree angle)</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Notes:</p>	<p><input type="checkbox"/> Client. <i>Consider replacing the mattress.</i></p>	<p><input type="checkbox"/> ASAP/AAA</p>	

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Client's last name: _____

Fall Prevention Assisted Home Safety Assessment

Usable Telephone is NOT next to bed? <input type="checkbox"/> Yes <input type="checkbox"/> No Notes:	<input type="checkbox"/> Client. <i>Place a cordless type or cell phone next to your bed at night or during naps.</i>	<input type="checkbox"/> ASAP/AAA	
Doorbell can NOT be heard by client in bedroom? <input type="checkbox"/> Yes <input type="checkbox"/> No Notes:	<input type="checkbox"/> Client. <i>Fix or replace doorbell with one that can be heard in bedroom.</i>	<input type="checkbox"/> ASAP/AAA	
Light switch is NOT at door entrance or light left on? <input type="checkbox"/> Yes <input type="checkbox"/> No Notes:	<input type="checkbox"/> Client. <i>Put in a night-light so you can see where you're walking. Some night-lights go on by themselves after dark.</i>	<input type="checkbox"/> ASAP/AAA	
Chair is NOT easy to get in/out of? <input type="checkbox"/> Yes <input type="checkbox"/> No Notes:	<input type="checkbox"/> Client. <i>If the chair is too low, add a leg riser. A chair that is too high or without arms should not be used, as it will not provide sufficient stability to get in & out of chair.</i>	<input type="checkbox"/> ASAP/AAA	

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Client's last name: _____

Fall Prevention Assisted Home Safety Assessment

<p>Client has difficulty moving in/out & through the room, reports bumping/tripping into things?</p> <p style="margin-left: 20px;"> <input type="checkbox"/> Yes <input type="checkbox"/> No </p> <p>Notes:</p>	<input type="checkbox"/> PCP Referral to clinical specialist	<input type="checkbox"/> ASAP/AAA	
<p>Client off balance when sitting at bedside?</p> <p style="margin-left: 20px;"> <input type="checkbox"/> Yes <input type="checkbox"/> No </p> <p>Notes:</p>	<input type="checkbox"/> PCP Referral to clinical specialist	<input type="checkbox"/> ASAP/AAA	
<p>Client does NOT have a handrail to assist getting in and out of bed if needed</p> <p style="margin-left: 20px;"> <input type="checkbox"/> Yes <input type="checkbox"/> No </p> <p>Notes:</p>	<input type="checkbox"/> PCP Referral to clinical specialist	<input type="checkbox"/> ASAP/AAA	

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Client's last name: _____

Fall Prevention Assisted Home Safety Assessment

Client makes frequent nighttime trips to bathroom? <input type="checkbox"/> Yes <input type="checkbox"/> No Notes:	<input type="checkbox"/> PCP Referral to clinical specialist	<input type="checkbox"/> ASAP/AAA	
Client holds or leans on furniture while ambulating? <input type="checkbox"/> Yes <input type="checkbox"/> No Notes:	<input type="checkbox"/> PCP Referral to clinical specialist	<input type="checkbox"/> ASAP/AAA	
Doorknobs/ furniture knobs are NOT easy-to-use? <input type="checkbox"/> Yes <input type="checkbox"/> No Notes:	<input type="checkbox"/> PCP Referral to clinical specialist	<input type="checkbox"/> ASAP/AAA	

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Client's last name: _____

Fall Prevention Assisted Home Safety Assessment

Closet clothing is NOT accessible; client needs a step stool or stands on tiptoes or chair? <input type="checkbox"/> Yes <input type="checkbox"/> No Notes:	<input type="checkbox"/> PCP Referral to clinical specialist	<input type="checkbox"/> ASAP/AAA	
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_____ Total # of bedroom hazards present	Total # of recommendations			
	_____ Client/landlord	_____ BHA	_____ ASAP/AAA	_____ PCP Referral to clinical specialist

Comments:

BATHROOMS: Look at all the bathrooms in the home.

Education	<ul style="list-style-type: none"> Use non-slip mats in the bathtub and on shower floors. Put grab bars inside and next to the tub or shower and next to the toilet. Make sure electrical appliances are a safe distance from the bathtub/shower. Notice the floors; tiles and or marble floors can be slippery when wet; deep pile carpet and transitions between rooms can be a tripping hazard
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HAZARD	RECOMMENDATION	Modification Completed?	Follow-up required?
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Client's last name: _____

Fall Prevention Assisted Home Safety Assessment

<p>Is the tub or shower floor slippery?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Notes:</p>	<p><input type="checkbox"/> Client. <i>Put a non-slip rubber mat or self-stick strips on the floor of the tub or shower.</i></p>	<p><input type="checkbox"/> ASAP/AAA</p>	
<p>Toilet paper roll is difficult to use & more than one outstretched arm distance from toilet?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Notes:</p>	<p><input type="checkbox"/> Client. <i>Have a toilet paper dispenser installed closer to the toilet.</i></p>	<p><input type="checkbox"/> ASAP/AAA</p>	
<p>Bathroom floor mat does not have a non-skid backing & hung on side of tub when not in use?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Notes:</p>	<p><input type="checkbox"/> Client. <i>Put non-skid backing on floor mat and hang up after bathing to dry.</i></p>	<p><input type="checkbox"/> ASAP/AAA</p>	
<p>Nightlight not available?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Notes:</p>	<p><input type="checkbox"/> Client. <i>Put a nightlight in the bathroom.</i></p>	<p><input type="checkbox"/> ASAP/AAA</p>	

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Client's last name: _____

Fall Prevention Assisted Home Safety Assessment

For frail elders at risk, anti-scald valves are NOT installed in showerhead &/or bathtub spout? <input type="checkbox"/> Yes <input type="checkbox"/> No Notes:	<input type="checkbox"/> Client/Landlord. <i>Replace valves.</i>	<input type="checkbox"/> BHA	<input type="checkbox"/> ASAP/AAA		
Faucets are NOT easy-to-use? <input type="checkbox"/> Yes <input type="checkbox"/> No Notes:	<input type="checkbox"/> Client/Landlord. <i>Replace faucets.</i>	<input type="checkbox"/> BHA	<input type="checkbox"/> ASAP/AAA		
Client has difficulty getting on & off the toilet? <input type="checkbox"/> Yes <input type="checkbox"/> No Notes:	<input type="checkbox"/> PCP Referral to clinical specialist		<input type="checkbox"/> ASAP/AAA		
Client has difficulty reaching/using faucets & controls? <input type="checkbox"/> Yes <input type="checkbox"/> No Notes:	<input type="checkbox"/> PCP Referral to clinical specialist		<input type="checkbox"/> ASAP/AAA		

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Client's last name: _____

Fall Prevention Assisted Home Safety Assessment

Client has difficulty reaching medicine cabinet? <input type="checkbox"/> Yes <input type="checkbox"/> No Notes:	<input type="checkbox"/> PCP Referral to clinical specialist	<input type="checkbox"/> ASAP/AAA	
Client has difficulty getting in and out of the bathtub or shower? <input type="checkbox"/> Yes <input type="checkbox"/> No Notes:	<ul style="list-style-type: none"> PCP Referral to clinical specialist <i>Have OT come in to put grab bars inside and next to the tub or shower and next to the toilet.</i> 	<input type="checkbox"/> ASAP/AAA	
Client reports need to sit to take a bath or shower. <input type="checkbox"/> Yes <input type="checkbox"/> No Notes:	<input type="checkbox"/> PCP Referral to clinical specialist	<input type="checkbox"/> ASAP/AAA	
Grab bars are incorrectly installed? <input type="checkbox"/> Yes <input type="checkbox"/> No Notes:	<ul style="list-style-type: none"> PCP Referral to clinical specialist <i>Have OT come in to put grab bars inside and next to the tub or shower and next to the toilet.</i> 	<input type="checkbox"/> ASAP/AAA	

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Client's last name: _____

Fall Prevention Assisted Home Safety Assessment

_____ Total # of bathroom hazards present	<i>Total # of recommendations</i> _____ Client/landlord _____ BHA _____ ASAP/AAA _____ PCP Referral to clinical specialist				
OUTDOORS: Look around outside the home.					
Education	<ul style="list-style-type: none"> Items you should have when leaving: glasses, hearing aid, walkers, canes, or crutches Elevators: block doors when entering or exiting; control the open button until safely in or out Escalators- remember to tie shoe laces; step to the middle of the stair; hold the hand rail Parking lots: be aware of wet or icy road surface; cracks and bumps in the road surface 				
HAZARD	RECOMMENDATION			Modification Completed?	Follow-up required?
Are there objects on the stairs? <input type="checkbox"/> Yes <input type="checkbox"/> No Notes:	<input type="checkbox"/> Client/Landlord. <i>Pick up things on the stairs; keep objects off stairs.</i>				
Are steps broken or uneven? <input type="checkbox"/> Yes <input type="checkbox"/> No Notes:	<input type="checkbox"/> Client/Landlord. <i>Repair damaged /broken steps.</i>	<input type="checkbox"/> BHA	<input type="checkbox"/> ASAP/AAA		

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Client's last name: _____

Fall Prevention Assisted Home Safety Assessment

<p>Is a light missing over the stairway and/or outside?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Notes:</p>	<p><input type="checkbox"/> Client/Landlord. <i>Add an outdoor light; consider a fixture with an automatic sensor.</i></p>	<p><input type="checkbox"/> BHA</p>	<p><input type="checkbox"/> ASAP/AAA</p>		
<p>Has the stairway light bulb burned out?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Notes:</p>	<p><input type="checkbox"/> Client/Landlord. <i>Have a friend or family member replace light bulb.</i></p>	<p><input type="checkbox"/> BHA</p>	<p><input type="checkbox"/> ASAP/AAA</p>		
<p>Are the handrails loose or broken? Are there missing handrails (either on one or both sides)?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Notes:</p>	<p><input type="checkbox"/> Client/Landlord. <i>Fix loose handrails or put in new ones. Make sure handrails are on both sides of the stairs and are as long as the stairs.</i></p>	<p><input type="checkbox"/> BHA</p>	<p><input type="checkbox"/> ASAP/AAA</p>		

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Client's last name: _____

Fall Prevention Assisted Home Safety Assessment

<p>Is threshold/steps unmarked and/or raised?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Notes:</p>	<p><input type="checkbox"/> Client/Landlord. <i>Mark end of steps or thresholds with contrasting tape or paint to increase awareness of changes in height.</i></p>	<p><input type="checkbox"/> BHA</p>	<p><input type="checkbox"/> ASAP/AAA</p>		
<p>Lack of a ramp for a wheelchair?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Notes:</p>	<p><input type="checkbox"/> Client/Landlord. <i>Have a ramp installed that will allow wheelchair access in & out of home.</i></p>	<p><input type="checkbox"/> BHA</p>	<p><input type="checkbox"/> ASAP/AAA</p>		
<p>Is an outdoor grab bar missing?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Notes:</p>	<p><input type="checkbox"/> Client/Landlord. <i>Have grab bar installed.</i></p>	<p><input type="checkbox"/> BHA</p>	<p><input type="checkbox"/> ASAP/AAA</p>		
<p>Uneven/cracked pavement?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Notes:</p>	<p><input type="checkbox"/> Client/Landlord. <i>Have pavement repaired. Avoid these areas when walking to & from the home.</i></p>	<p><input type="checkbox"/> BHA</p>	<p><input type="checkbox"/> ASAP/AAA</p>		

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Client's last name: _____

Fall Prevention Assisted Home Safety Assessment

Seasonal debris (ice, snow, leaves, weeds) on driveway/walkway? <input type="checkbox"/> Yes <input type="checkbox"/> No Notes:	<input type="checkbox"/> Client/Landlord. <i>Have a friend or family member clear the driveway/walkway.</i>	<input type="checkbox"/> BHA	<input type="checkbox"/> ASAP/AAA		
Doorbell is NOT in working order & heard by client? <input type="checkbox"/> Yes <input type="checkbox"/> No Notes:	<input type="checkbox"/> Client/Landlord. <i>Have doorbell fixed or replaced.</i>	<input type="checkbox"/> BHA	<input type="checkbox"/> ASAP/AAA		
Client can NOT easily open/close door, deadbolt & other locks, enter/exit dwelling, view visitors? <input type="checkbox"/> Yes <input type="checkbox"/> No Notes:	<input type="checkbox"/> PCP Referral to clinical specialist		<input type="checkbox"/> ASAP/AAA		
_____ Total # of outdoor hazards present	Total # of recommendations _____ Client/landlord _____ BHA _____ ASAP/AAA _____ PCP Referral to clinical specialist				

NOTE: Referrals to ASAP/AAA are made during the 2 week follow-up call if the client is unable to individually manage the checklist modification.

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Client's last name: _____

Fall Prevention Assisted Home Safety Assessment

INITIAL VISIT						
Total # of Referrals Made:	___ Client/Landlord	___ BHA Referral	___ PCP Referral to a Clinical Specialist	___ Emergency Services		
Client Recommendations/ Reinforcement	___ Tai Chi and MOB		___ MOB			
2 WEEK FOLLOW-UP PHONE CALL						
Total # of Referrals Made:	___ Client/Landlord	___ BHA Referral	___ ASAP/AAA			
Client Recommendations/ Reinforcement	___ Tai Chi and MOB		___ MOB			
FOLLOWUP (60 DAYS)						
Total # of Referrals Completed:	___ Client/Landlord	___ BHA Referral	___ PCP Referral to a Clinical Specialist	___ Emergency Services	___ ASAP/AAA	# changes client refused
Client Recommendations/ Reinforcement	___ Tai Chi and MOB		___ MOB			

Log of Recommendation & Contact Dates

RECOMMENDATIONS	COMMENTS
Initial Visit	Date: _____
<input type="checkbox"/> Client	
<input type="checkbox"/> Landlord	
<input type="checkbox"/> BHA	

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Fall Prevention Assisted Home Safety Assessment

<input type="checkbox"/> PCP (clinical referrals)	
<input type="checkbox"/> Other	
<input type="checkbox"/> Emergency Services	
<input type="checkbox"/> Program	
<input type="checkbox"/> Mandated reporting	
<input type="checkbox"/> Services refused (explain why)	
<input type="checkbox"/> Notes (free text)	
RECOMMENDATIONS	COMMENTS
Telephone Follow-up	Date/Notes (1 st call 2 weeks after initial home visit)
Date of 1 st call	
Date of 2 nd call	
Date of 3 rd call	
RECOMMENDATIONS	COMMENTS
Follow-up home visit	Date: (60 days after initial home visit)
<input type="checkbox"/> Client	
<input type="checkbox"/> Landlord	
<input type="checkbox"/> ASAP/AAA	
<input type="checkbox"/> BHA	
<input type="checkbox"/> PCP (clinical referrals)	
<input type="checkbox"/> Other	
<input type="checkbox"/> Emergency Services	
<input type="checkbox"/> Program	
<input type="checkbox"/> Mandated reporting	
<input type="checkbox"/> Services refused (explain why)	
<input type="checkbox"/> Notes (free text)	

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Fall Prevention Assisted Home Safety Assessment

7. Present and distribute ASAP information
8. Review key points with client, talk through follow up and next steps, and give client encouraging and empowering words

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