Risk for Falls Screening

Patient: _____ DOB _____ Date _____

Direction: Check the box in front of any question that applies to you

	****I have fallen in the past year If yes, how many times? _____ Any with injury? Yes or No**	**Points 2**
	****Sometimes I feel unsteady when I am walking.**	**1**
	****I worry about the possibility of falling**	**1**
	I use or have been advised to use a cane or walker.	**2**
	I steady myself by holding onto furniture when walking at home.	**1**
	I need to push with my hands to stand up from a chair	**1**
	I have trouble stepping off or stepping up onto a curb	**1**
	I often have to rush to the toilet or get up in the middle of the night	**1**
	I have lost feeling in my feet	**1**
	I take medications that make me feel light-headed	**1**
	I take medication to help me sleep or to treat depression or anxiety	**1**
	Total points _____	

Directions for Nursing Staff: TUG to be performed for any patient with:

1. **Multiple falls reported**
2. **Any starred item reported as "Yes"**
3. **Score of ≥ 4**