

## SHIFT - Falls / Fractures - Assessment

If patient fell:

Date of last fall (mm/dd/yy):

Circumstances of fall (check all that apply):

- ☐ Loss of consciousness
- ☐ Tripped/stumbled over something
- ☐ Lightheadedness/palpitations
- ☐ Unable to get up within 5 minutes
- ☐ Needed assistance to get up

Cognition: Ask patient to repeat 3 unrelated words (e.g., ball, pencil, cat)  
Inform patient that you will ask them to repeat these words in a few minutes

Orthostatics: (measure after 1 - 2 minutes in specified position)

Lying: BP:                      Pulse:

Standing: BP:                      Pulse:

Cognition: Ask patient to repeat the previous 3 words (from above)

3-item recall:                      ☐ pass   ☐ fail

Vision

- ☐ Noticed recent vision changes
- ☐ Eye exam in past year

If NO eye exam in the past year,

Visual Acuity today:   ☐ pass   ☐ fail

Psychotropic medications (specify):

- ☐ Neuroleptics:
- ☐ Benzodiazepines:
- ☐ Antidepressants:

Two or more drinks of alcohol each day   ☐ Yes   ☐ No

Other conditions (e.g., Parkinson's, CVA, cardiac, severe OA)   ☐ Yes   ☐ No

Specify: