This patient had a fall / found on the floor on:

**Date:** ____________________ **Time:** ____________________

**Nursing Checklist** (tick all completed)
- Reassess moving and handling
- Reassess Falls Care Plan

**Informed:**
- Doctor
- Family / Carer / NoK

**Location Of Fall**

Datix No: ____________________

**Completed By**

Sign  __________________________________________________________
Print  __________________________________________________________

**Doctor’s Checklist**

- Time + Circumstances of fall
- Witnessed? Collateral history
- Palpitations / SOB / chest pain
- Relevant medical history
  - Loss of consciousness? y □ n □
  - Recurrent faller y □ n □
  - On any Anticoagulation? y □ n □
  - Balance + / or gait impairment y □ n □

**Examination - Tick and document in notes**

- Obs (incl BM + GCS)
- Other relevant systems
- Cardiovascular exam
- Neurological exam
- Likely cause of fall

**Injury Sustained**

Include head, c-spine, hips, wrists

Mark image with an X as appropriate

No injury  □

Start neuro obs if head injury risk or unwitnessed fall

**Investigations requested (please tick)**

- ECG  □
- X-ray  □
- Lying/ standing BP  □
- Pain Management plan  □
- Clotting screen required?  □

**Prevention**

- Assess AMT Score □
- Consider bone protection □
- Assess for delirium □
- Review meds □
- Other □

**Completed by**

Sign  __________________________________________________________
Print  __________________________________________________________

Give a summary of the incident and any action taken to the right of this sticker.