My Fall Prevention Action Plan

My name: _____Date of Birth:_____Date: _____

During my fall risk evaluation I was found to be: ☐ low risk ☐ moderate risk ☐ high risk

In the past year, I have fallen: __0 or 1 time __2 or more times

What was covered and talked about during my appointment:	
My fall history?	☐ Yes ☐ No
Strength and balance exercises?	☐ Yes ☐ No
Home safety and fall hazards and I was given a home safety checklist?	☐ Yes ☐ No
My gait, strength and balance were assessed?	☐ Yes ☐ No
Supplement/medications for bone health?	☐ Yes ☐ No

To help reduce my risk for falls, my doctor also reviewed the following action items with me:	
My medications were reviewed and the following changes were made:	
My vision was checked. My doctor told me:	
My blood pressure is too high/low. My doctor to told me to monitor it this often:	
We talked about my pain. My doctor told me:	
We talked about my physical activity. My doctor gave me a prescription (Rx) for exercise:	
I was refereed for an osteoporosis screening: I was referred to a fall prevention program:	
I was referred to physical therapy to help my gait, strength and balance:	
I was referred to a podiatrist:	
I was referred to case management:	
My doctor recommended I get an emergency response system:	
I was referred to SCAN's Fall Prevention podcast https://www.scanhealthplan.com/members/healthy-at-any-age-podcasts	
My doctor's office would like to follow up with me (by phone or in person) about my fall prevention action plan within the next 30 days. My appointment is scheduled for:	

Provider's Signature_____