My Fall Prevention Action Plan

My name: _____ **Date:** _____

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 this prescription (Rx) for exercise:	
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:	
I have an appointment for an osteoporosis screening:	
My doctor recommended I get an emergency response system:	
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:	