Fall Risk Factors that Matter Most to Me

[Name of Health System] **Name:**
Study ID: **Date:**

My priority fall risk factor(s)	My plans
1.	[Please refer to preliminary independence plan . . . . . or Specific preliminary plan(s)]
2.	
3.	[Please refer to preliminary independence plan . . . . . or Specific preliminary plan(s)]
4.	
5.	[Please refer to preliminary independence plan . . . . . or Specific preliminary plan(s)]

Initial Visit: Educational Materials Provided

- ✓ Falls and Fractures Age Page
- ✓ How to Get Up from a Fall
- ✓ Eldercare Locator
- ✓ Community Safety

My Additional Educational Materials:

- ☐ Home Exercise Handout
- ☐ Avoid Bad Effects of Medications
- ☐ Sleep Hygiene
- ☐ Postural Hypotension
- ☐ Proper Shoes
- ☐ Home Safety
- ☐ Travel Safety
- ☐ Osteoporosis Age Page
- ☐ Vitamin D Fact Sheet
- ☐ Cataracts
- ☐ Cracked sidewalk
- ☐ All About Calcium
- ☐ Dairy Sources of Calcium
- ☐ Non-Dairy Sources of Calcium
- ☐ Nocturia

Call your Falls Care Nurse, _____ at ### ### #### if you:

- Are unable to keep scheduled appointments
- Have changed your mind regarding the plans you have made
- Have received medical care for a fall or following a fall

Follow-up:

My Nurse will Call Me: Care Plan follow-up call, 3-4 month call, 9 month call
My Visits: 6 month visit mm/dd/yyyy, 12 month visit mm/dd/yyyy