**CHAT Team Falls Clinic Proforma**

Name: DOB

NHS No: GP

**History of falls**: consider Number of falls, where they occurred, time of day, any preceding symptoms ie dizziness, palpatations

**PMH**

**Observations:**

Temp Pulse Respirations Urinalysis BM (if diabetic)

B/P lying B/P on standing B/P after 1min B/P after 2mins

**If there is a drop of 20mmHg systolic or >10mmHg diastolic, then issue the postural hypotension information leaflet**

**Physical Examination:**

Heart sounds/murmurs Evidence of OA

CNS examination Foot exam –bunions, nail care

Cognition – MMSE if indicated Vision

Pain – use recognised pain tool Hearing

Incontinence of urine Yes □ No □

Incontinence of stoolYes □ No □

**Medication Review :**

Polypharmacy Yes □ No □

Bone protection prescribed Yes □ No □

Bone protection indicated Yes □ No □ Frax score

**Mini Musculo Skeletal assessment**

Frat tool completed Yes □ No □

Does the resident sway on standing Yes □ No □

Aid in use? Yes □ No □ If Yes, what type?.................................. Help needed for transfers? Yes □ No □

Is it the correct height Yes □ No □ Is it in good condition Yes □ No □

Help needed for transfers? Sit to stand Yes □ No □

From bed Yes □ No □

From chair Yes □ No □

From toilet seat Yes □ No □

**Room Enviroment.**

Lighting in room: …………………………………………………….. Call bell/sensors ………………………………………………………

Grab rails…………………………………………………………………… Flooring……………………………………………………………………..

Clutter in room…………………………………………………………. Appropriate seating……………………………………………………

**Further Investigations required: (**Tick all that apply)

ECG □

Tilt Table+/- CSM □

ECHO □

24 hour tape □

MMSE/Cognitive testing □ Bloods:- TFTs/B12/Folate/CCA □

**Cause of Falls:**

**Action Plan:** (to include onward referrals to audiology/ophthalmology/syncope clinic/psychiatry etc)

**Name of completing Physician:**

**Date:**

**Referral to Physio required Yes □ No □**

**CC**

GP & Care Home