NEW YORK STATE OF OPPORTUNITY. | Office for People With Developmental Disabilities

ANDREW M. CUOMO
Governor

THEODORE KASTNER, MD, MS
Acting Commissioner

Post-Fall Review

Refer to 'Post-Fall Review Information and Instructions' when filling out this 4-part form.

Part 1 – Basic Information

Name of Individual Who Fell:		
Name and Title of Staff Member Completing Form:		
Date and Time of Fall:	Date Incident Reported:	House/Program:

Part 2 – Post-Fall Review

Indications Before the Fall	☐ Dizziness ☐ Unconsciousness/Fainted ☐ Seizure ☐ Disorientation/Confusion ☐ Leg weakness/Gave way	☐ Pushed/Shoved ☐ Rushing/Rushed ☐ Rushing to the bathroom ☐ Loss of balance ☐ Trip or Slip	☐ Unknown ☐ Other (list):
Location of the Fall	☐ Living Room ☐ Dining Room ☐ Bedroom ☐ Bathroom ☐ Outdoor area (be specific): ☐ Community (be specific):	☐ Kitchen ☐ Stairs ☐ Basement ☐ Vehicle	☐ Day Program ☐ Unknown ☐ Other (list):
Activity at the Time of Fall	☐ Assisted Transfer ☐ Unassisted Transfer ☐ Walking with staff ☐ Walking unassisted ☐ Behavioral Incident ☐ Walking with assistive device (e.g., walker, cane) ☐ Transportation (be specific):	☐ Individual found on floor ☐ Staff lowered to floor ☐ Lowered self to floor ☐ Getting up or down ☐ Reaching for something	☐ Bathing ☐ Toileting ☐ Unknown ☐ Other (list):
Environmental Factors Contributing to the Fall	☐ Environmental Supports ☐ Floors: Spills/dampness ☐ Floors: Clutter/obstacles ☐ Floors: Rugs unsecured ☐ Unstable/broken furniture	☐ Footwear issues ☐ Poor lighting ☐ Outdoor conditions ☐ Wheelchair ☐ Ambulation Device	☐ Unknown ☐ Other (list):
Was a Fall Prevention Device in Use at the Time of Fall?	☐ Yes (list):	☐ No	☐ Unknown
Injury	☐ None apparent or noted ☐ Yes – Required only first aid ☐ Yes – Required medical attention and/or hospitalization		

Medications Prescribed at Time of Fall	☐ Antihistamine ☐ Antihypertensive ☐ Anti-seizure	☐ Laxatives ☐ Diuretics ☐ Hypoglycemic	☐ Narcotics ☐ Psychotropic ☐ Prostate	☐ Other (list):
Recent Changes in Medications	☐ Medications not taken as prescribed ☐ Medications added or changed within 30 days (including dose & frequency)			

Part 3 - Supervisory Review and Follow-up Actions

Name and Title:
Date of Review:
Plan for Follow-up Action(s): Verification of Plan Implementation: Plan verified by (Name/Title): _____ Date of verification: _____

Part 4 – Incident Reporting

Was the fall reported as any of the following types of incidents or occurrence?
(Check one of the following)

☐ Agency incident/occurrence that does not rise to the level of a Part 624 incident – A fall that results in no injury or an injury that requires medical care that is not beyond first aid.

☐ Injury, minor notable occurrence – Requires treatment by a medical professional and is more than first aid

☐ Reportable significant incident – Injury, with hospital admission

☐ Reportable abuse or neglect

☐ Other (be specific):