First Name:_____

Last Name:_____

Date of Birth:_____

NHS No:_____

Shropshire Community Health NHS
NHS Trust

Level 2: Multifactorial Falls and Fracture Risk Assessment

Patient given consent to assessment: Yes ☐	**Action/ Refer:**	**Date** referred/ initiated	**Initial**
History of Falls: Number of falls in last 12 months:			
Cause of fall(s)			
Suspected medical reason for fall ☐ Unexplained fall ☐ Blackout ☐ Legs gave away ☐	Refer DAART ☐ PBDU ☐ GP ☐		
Slip ☐ Trip ☐ Loss of Balance ☐ Over Reached ☐	Comments:		
Associated Factors: Activity at time of fall: Footwear: Location of fall: Time of fall:	Comments:		
Injury Sustained: Yes ☐ No ☐ Fracture ☐ Dislocation ☐ Laceration ☐ Sprains ☐ Bruises ☐ Joint Pain ☐	Comments:		
Dizziness: Yes ☐ No ☐ described as: Sensation of Spinning ☐ Sensation of Spinning when turning over in bed ☐ Occurs when moving from Lying – Sitting – Standing ☐ Head and Neck Movements ☐ Dizziness before falling ☐	Pulse = Lying BP = Sitting BP = Standing BP Immediate = 3 min = If BP continues to drop, continue to take BP until levels out and record = Unable to stand ☐ Refer DAART ☐ PBDU ☐ GP ☐		
Acute illness at time of fall ☐ Acute illness suspected at assessment ☐ Uncontrolled diabetes? ☐ Ear infection? ☐ Chest infection? ☐ Urine infection? ☐	Temperature …… Blood sugars …… Ears checked …... Oxygen sats ……. Sputum sample ☐ Urinalysis …… Refer DAART ☐ PBDU ☐ GP ☐ Nurse ☐		
Medication: Compliant Yes ☐ No ☐ EMIS attached ☐ Taking four or more medications Yes ☐ No ☐ Taking anti-coagulant medication Yes ☐ No ☐ Recent changes in medication Yes ☐ No ☐ Recent change in dose Yes ☐ No ☐ Problems taking medication Yes ☐ No ☐ Forgetting ☐ Swallowing ☐ Upset Stomach ☐ Opening bottles ☐ Other☐	Refer: Practice Based Pharmacist ☐ GP ☐ for medication review Speech and Language Therapist ☐ Social Worker ☐		
Changes to Lifestyle: Yes ☐ No ☐ ↓ ADL ☐ ↓ Mobility ☐↓ Social Activities ☐ Fear of Falling ☐ Visual analogue scale (VAS) 0 -10……	FES-I score ……. Refer GP ☐ Falls Prevention Service ☐ Salford Fear of Falling Leaflet ☐		
Able to Get Up From Floor Yes ☐ No ☐	Transfer Practise ☐ How to manage a Fall Leaflet ☐ Refer Physio ☐ Falls Prevention Service ☐		

Sign:	Print Name:	Initial:	Designation:	Date:
Sign:	Print Name:	Initial:	Designation:	Date:
Sign:	Print Name:	Initial:	Designation:	Date:

First Name:_____

Last Name:_____

Date of Birth:_____

NHS No:_____

Shropshire Community Health NHS
NHS Trust

	Action/ Refer:	Date referred/ initiated	Initial
Relevant Past Medical History: Parkinson's Disease☐ Stroke☐Osteoporosis☐ Osteoarthritis☐ Rheumatoid Arthritis□ Joint Replacement ☐ Heart Condition☐ Circulation Problems ☐ Diabetes ☐ ↑BP ☐ ↓BP ☐ Asthma ☐ Bronchitis ☐ Emphysema ☐ Epilepsy ☐ Peripheral Neuropathy ☐ Other ☐ …….. Pain □ Visual analogue scale(VAS) 0 -10……	Condition(s) ……. …….. …….. worsening Refer GP ☐ Other ☐ please state…….		
Osteoporosis: Diagnosis Yes ☐ No ☐ Takes bisphosphonate e.g. alendronate,risedronate as prescribed Yes ☐ No ☐ Discontinued taking ☐ unable to follow advice for taking ☐ Takes calcium / Vitamin D as prescribed Yes ☐ No ☐	Refer GP ☐		
Fracture Risk: Over 75 years of age with previous fragility fracture and not prescribed bisphosphonate ☐	Refer GP to consider commencing Bisphosphonate without need for DEXA ☐ (Following National /Local Guidelines)		
All other patients at risk of falls complete FRAX (see separate FRAX form)	Refer to GP with copy of FRAX recommendations identified below: Consideration of treatment without need for DEXA ☐ Consideration of referral for DEXA ☐ Lifestyle advice and reassurance given ☐		
Mental Health: Current / Recent Psychiatric Care Yes ☐ No ☐ Diagnosis: Anxiety ☐ Depression ☐ Bereavement ☐ Dementia ☐ Delirium ☐ Severe Memory Problems v Learning Disability ☐ Other ☐	Validated Cognitive Impairment Score ☐ HADS score ☐ …….. GP depression scale …….. Refer GP ☐ Bereavement Counselling ☐		
Health and Wellbeing: Smoker? Yes ☐ No ☐	Refer: Help to Quit ☐ Lifestyle Advice given ☐		
Alcohol: Yes ☐ No ☐ How much ?..... Recommended limits: 21 units per week for men 14 units per week for women	Refer GP ☐ Advice given☐		
Nutrition Problems: Yes ☐ No ☐ Badly Fitting Dentures ☐ Meal Preparation ☐ Handling Meals/Drinks ☐ Visually Impaired ☐ Poor Appetite ☐ Poor Intake ☐ Digestion Problems ☐Swallowing Problems ☐ Special Dietary Needs ☐ Unintentional Weight loss ☐ Other ☐	Refer GP ☐ SALT ☐ O.T ☐ Social Services ☐ Dietician ☐ Dentist ☐ Age UK Leaflet ☐		
Dehydration: Yes ☐ No ☐ Confusion ☐ UTI ☐ Decrease Urine Output ☐ Constipation ☐ Signs of Thirst ☐ Dry Mouth ☐ Clarity of Speech☐	Comments: Refer GP ☐ Nurse ☐ Advice given on recommended fluid intake 6-8 glasses per day ☐		
Continence **Known to Continence Service** Yes ☐ No ☐ **Bladder Problems** Yes ☐ No ☐ Difficulty Passing Water ☐ Stress Incontinence ☐ Urge Incontinence ☐ Nocturia ☐ Other ☐ **Bowel Problems** Yes ☐ No ☐ Constipation ☐ Diarrhoea ☐	Refer: District Nurses ☐ Continence Advisor ☐		

Sign:	Print Name:	Initial:	Designation:	Date:
Sign:	Print Name:	Initial:	Designation:	Date:
Sign:	Print Name:	Initial:	Designation:	Date:

First Name:_____

Last Name:_____

Date of Birth:_____

NHS No:_____

Shropshire Community Health NHS
NHS Trust

	Action/ Refer:	Date referred/ initiated	Initial
Eyesight: **Eyes Checked in Last 12-Months** Yes ☐ No ☐	Comments:		
Problems: Yes ☐ No ☐ Glaucoma ☐ Cataract ☐ Macular Degeneration ☐ Diabetic Retinopathy ☐ Change in Vision ☐ Registered Blind ☐ Bi Focals ☐ Varifocals ☐ Spectacles Damaged ☐ Spectacles Not Worn ☐ Spectacles Not Clean ☐ Insufficient Lighting ☐	Refer: Sensory Impairment Team ☐ Opticians ☐ Outside Clinic for Housebound Patients ☐ Advice given ☐ Age UK Leaflet ☐		
Hearing: Known to Hearing Service Yes ☐ No ☐ Hearing Aid Yes ☐ No ☐ Left ☐ Right ☐ Both ☐	Comments:		
Problems: Yes ☐ No ☐ Ear Wax ☐ Hearing Loss ☐ Hearing Aid Problems ☐ Hearing Doorbell ☐ Hearing Telephone ☐ Hearing Smoke Alarm ☐	Refer GP ☐ Nurse ☐ Sensory Impairment Team ☐ Sensory impairment resource ☐ Community Council Shropshire ☐		
Footcare: **Manages Self** Yes ☐ No ☐ **Problems** Yes ☐ No ☐ Arthritis ☐ Diabetes ☐ In-growing Toenails ☐ Corns ☐ Calluses ☐ Bunions ☐ Heel Fissures ☐ Tired/Aching Feet ☐ Other ☐ **Appropriate Shoes / Slippers** Yes ☐ No ☐	Refer: Podiatry in Clinic ☐ Footwear Brochure ☐ Advice given ☐		
Mobility: Present Mobility Aids: None ☐ 1 Stick ☐ 2 Sticks ☐ Fisher Stick ☐ Crutches ☐ Frame ☐ 2 Wheeled Walking Frame ☐ 3 Wheeled Walker ☐ 4 Wheeled Walker ☐ Wheelchair ☐ Electric Wheelchair ☐	New ferrule fitted ☐ Replacement of Walking Aid☐ 2nd walking aid fitted Upstairs ☐ Refer: Physio ☐		
Level of Activity: Mobilises indoors with supervision ☐ Mobilizes independently indoors ☐ Mobilises outdoors with supervision ☐ Mobilizes outdoors independently<½ mile☐ <1 mile☐ >1 mile☐ **Current or Recent Exercise** Yes ☐ No ☐ Physiotherapy ☐Home Exercise ☐Community Exercise ☐Other ☐ Average length of time remains seated :	Comments: Advice given on: Pressure care ☐ Sedentary behaviour ☐ Refer to: Nurse ☐ PUP Team ☐		
Lower Limb Strength: Is patient able to stand from chair of knee height without using their arms Yes ☐ No ☐ **Balance:** Does patient report being unsteady or having problems with their balance Yes ☐ No ☐ Is patient observed to be unsteady or have problems with their balance (Watch them get up and go) Yes ☐ No ☐	Refer: Physio ☐ Tinnetti score Gait …… Balance…….. TUAG score 180 turn…….steps		
Interested in Exercises to Improve Strength & Balance: Yes ☐ No ☐ Able to follow instructions Yes ☐ No ☐ **Interested in Group Setting ☐ 1:1 at Home ☐**	Refer for Otago/PSI group exercise programme : Falls Prevention Service (Shropshire) ☐ PBDU (Telford) ☐ Locality Physio for very frail / urgent 1:1 Otago exercise ☐		

Sign:	Print Name:	Initial:	Designation:	Date:
Sign:	Print Name:	Initial:	Designation:	Date:
Sign:	Print Name:	Initial:	Designation:	Date:

First Name:_____

Last Name:_____

Date of Birth:_____

NHS No:_____

Shropshire Community Health NHS
NHS Trust

	Action/ Refer:	Date referred/ initiated	Initial:
Home Situation **Lives with:** Alone ☐ Spouse ☐ Relative ☐ Friend ☐ Other ☐ **Property** Privately Owned ☐ Privately Rented ☐ Council ☐ Housing Association ☐ Sheltered Housing ☐ Other ☐ **Type** Detached ☐ Semi ☐ Terraced ☐ Bungalow ☐ Ground Floor Flat ☐ Flat with Lift ☐ Flat without lift ☐ **Services in Place:** Yes ☐ No ☐ Day Centre ☐ Care Package ☐ Private Help ☐ Respite ☐ Luncheon Club ☐ Meals on Wheels ☐ Other ☐ …….. **Lonely / Isolated** Yes ☐ No ☐	Comments: Refer: Social Services ☐ Age UK ☐ Red Cross ☐ Crossroads ☐		
Able to Use Telephone Yes ☐ No ☐ **Emergency Measures** Yes ☐ No ☐ Pendant Alarm ☐ Pull cord ☐ Cordless Phone ☐ Mobile ☐ **Used Appropriately** Yes ☐ No ☐ **System Test Working / Not Working**	Care Alarm Leaflet issued ☐ Refer: Social services ☐ Red Cross ☐ Age UK ☐ Other ☐ ……..		
Smoke Alarm Yes ☐ No ☐	Referred: Fire Service ☐		
Benefits Yes ☐ No ☐ Attendance Allowance ☐ Disability Allowance ☐	Referred to ……. …… for Benefits Check ☐		

PERSONAL CARE	**INDEPENDENT**	**SUPERVISION**	**ASSISTANCE**	**UNABLE**	**EQUIPMENT**	**COMMENTS**
Washing						
Dressing						
Grooming						
Meal Preparation						
Drink Preparation						
Laundry						
Cleaning						
Food Shopping						
TRANSFERS						**COMMENTS**
Chair						
Toilet Downstairs						
Toilet Upstairs						
Bath/Shower						
Bed						
Steps						
Stairs						

Refer: Independent Living Service ☐ Social Services ☐ Occupational Therapist ☐ Red Cross ☐ Age UK ☐
Mears Shropshire Handyperson Service ☐ Home Improvement Agency (Telford) ☐

Results of any tests/ investigations/ additional relevant information:

Referring on to other services within this pathway please send copy of this Level 2 MFFRA with any action plan agreed with patient and record in patient notes

Sign:	Print Name:	Initial:	Designation:	Date:
Sign:	Print Name:	Initial:	Designation:	Date:
Sign:	Print Name:	Initial:	Designation:	Date: