



## Proforma for medical assessment after an inpatient fall

Patient name and identifier:

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Date and time of the fall:

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Narrative of the fall:

Witnessed/ unwitnessed?

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Location of patient during assessment eg floor/bed/chair:

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How was patient moved off the floor?

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NEWS2 score: \_\_\_\_\_

GCS: \_\_\_\_\_ Motor: \_\_\_\_\_ Verbal: \_\_\_\_\_ Eyes: \_\_\_\_\_

BM: \_\_\_\_\_

Primary survey:

**Airway:** Patent (Yes/No): \_\_\_\_

Concerns about C-spine (Yes/No): \_\_\_\_

**Breathing:** RR: \_\_\_\_\_ O2 sats: \_\_\_\_\_

**Circulation:** BP: \_\_\_\_\_ HR: \_\_\_\_\_

**Disability:** \_\_\_\_\_

**Exposure:** \_\_\_\_\_

Actions from primary survey:

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_



## Secondary survey:

### Head:

Reported head injury (Yes/No): \_\_\_\_

Visible signs of head injury (Yes/No): \_\_\_\_

Findings:

Conclusion:

Indication for CT head (Yes/No): \_\_\_\_

Indication for Neuro obs (Yes/No): \_\_\_\_

**C-spine:** Suspected C-spine injury (Yes/No): \_\_\_\_

If yes, immobilised (Yes/No): \_\_\_\_

Findings:

Conclusion:

CT C-spine indicated (Yes/No): \_\_\_\_

**Thoracic/lumbar spine:** Suspected thoracic/lumbar fracture (Yes/No): \_\_\_\_

Abnormal neurology (Yes/No): \_\_\_\_

If yes, immobilised (Yes/No): \_\_\_\_

Findings:

Conclusion:

Imaging indicated (No/X-ray/CT): \_\_\_\_



**Chest:** Suspected fracture: \_\_\_\_\_

Findings:

Conclusion:

\_\_\_\_\_

CT indicated (Yes/No): \_\_\_\_

**Abdomen:**

Findings:

**Hip/pelvis:** Suspected hip/pelvic fracture (Yes/No): \_\_\_\_

Findings:

Conclusion:

\_\_\_\_\_

Imaging indicated (NA/X-ray hip/X-ray pelvis/CT hip/CT pelvis/trauma): \_\_\_\_\_

**Extremities – bones/joints/skin all 4 limbs**

Right upper limb: \_\_\_\_\_

Left upper limb: \_\_\_\_\_

Right lower limb: \_\_\_\_\_

Left lower limb: \_\_\_\_\_

X-ray indicated (Yes/No): \_\_\_\_



Pain score reviewed (Yes/No): \_\_\_\_

Analgesia reviewed (Yes/No): \_\_\_\_ Time of administration of analgesia (mins): \_\_\_\_

Anticoagulation/ antiplatelets reviewed (Yes/No): \_\_\_\_

Delirium screen (e.g 4AT) (Yes/No): \_\_\_\_

Is delirium suspected? (Yes/No): \_\_\_\_

Triggers identified:

Other comments/investigations ordered:

### Summary:

Cause of fall:

Injuries sustained:

Handover arrangements/outstanding assessments:

Event reported as per local policies (Yes/No): \_\_\_\_

\*If not reported, ask appropriate personnel to report the event.

Is duty of candour required (Yes/No): \_\_\_\_

\*If yes, determine who would do this: \_\_\_\_\_

Date/time completed

Name/Signature