BOCA RATON
REGIONAL HOSPITAL

OUTPATIENT FALLS RISK ASSESSMENT

Dear Patient,

In an effort to provide a safer environment while you are in our care, please answer the following questions so that we may determine your risk for falling.

YES	NO	
☐	☐	Have you fallen in the last year?
☐	☐	Do you have a fear of falling that interferes with your daily activities?
☐	☐	Do you use an assistive device?

NOTE: If you have answered "yes" to any of the above questions, a trained clinician will meet with you briefly prior to your exam.

_____ _____

Patient Signature Date

2134149158

Form ID: 2134 **149158**
Rev Date: 04/2009