**Post-Fall SPLATT Assessment**

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| **Name of Individual:** |  | **Date and Time of Fall:** |  |
| **Name of Staff Person Completing Assessment:** |  |

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| **1) Symptoms before the fall****If possible, ask individual “Why do you think you fell?”** | **[ ]**  Dizziness | **[ ]**  Disorientation/Confusion | **[ ]**  Seizure |
| **[ ]**  Trip/slip | **[ ]**  Unconsciousness/fainting | **[ ]**  Unknown |
| **[ ]**  Loss of balance | **[ ]**  Pushed/Shoved | **[ ]**  Other (list): |
| **[ ]**  Legs gave way/Leg weakness | **[ ]** Experiencing urgency (moving quickly) |  |
| **[ ]** Community **[ ]** Outdoors |
| **[ ]**  Living Rm/Dining Rm  | **[ ]**  Stairs  | **[ ]**  Unknown |
| **[ ]**  Bedroom  | [ ]  Basement  | **[ ]**  Other (list): |
| **[ ]**  Bathroom  | [ ] Vehicle |  |
| **[ ]**  Kitchen  | **[ ]**  Day Program |  |
| **3) Activity (at time of fall)****If possible, ask the individual “What were you doing when you fell?”** | **[ ]**  Transfer  | **[ ]**  Person found on floor  | **[ ]** Behavioral  Incident |
| **[ ]**  Walking with assistance | **[ ]**  Person lowered self to floor |
| **[ ]**  Walking unassisted | **[ ]** Staff lowered person to floor **[ ]** Bathing |
| **[ ]**  Reaching for something | **[ ]** Getting up or down |  **[ ]** Toileting  |
| **[ ]** Walking with a cane, walker, or other assistive device |  **[ ]** Unknown |
| **[ ]**  Other: |  |  **[ ]** Transportation |
| **4) Environmental factors contributing to the fall*****(check all that apply)*** | **[ ]**  Clutter/obstacles | **[ ]**  Wheelchair | **[ ]** Unknown |
| **[ ]**  Floor spills | **[ ]**  Improper footwear | [ ]  Other: |
| **[ ]** Rugs | [ ]  Outdoor conditions |
| **[ ]** Unstable/broken furniture **[ ]**  Poor lighting |
| **5) Was a fall prevention device in use at the time of fall? (**Ex. Gait belt, alarm) | **[ ]**  Yes, describe: | **[ ]** No | **[ ]** Unknown |
| **6) Injury** | **[ ]**  None apparent or noted |
| **[ ]**  Yes, Required only first aid |
| **[ ]**  Yes, Serious injury (required medical attention and/or hospitalization) |
| **7) Medications prescribed at time of fall** | **[ ]**  Antihistamine **[ ]** Laxatives **[ ]** Narcotics**[ ]**  Antihypertensive **[ ]** Diuretics **[ ]** Psychotropic**[ ]**  Anti-seizure **[ ]** Hypoglycemic **[ ]** Prostate Meds.**[ ]**  Unknown |
| **7a) Recent changes in medications** | **[ ]**  Medications not taken as prescribed **[ ]**  Medications (including dose, freq.) added or changed within last 30 days**[ ]** Unknown |