**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 | | | |