McAlester Regional/Zoellner Medical Group Fall Risk Assessment

Patient Name: _____ DOB: _____

Please complete all fields.

1.) Have you had a fall within the last 12 months? Y____ N____
2.) How many? _____
3.) Did any of these falls result in serious injury? Y___ N___
4.) Do you require assistance getting in and out of bed? Y___ N___
5.) Do you require assistance getting to and from the restroom? Y___ N___
6.) Do you require a: Walker Wheelchair Cane (circle one)

Please note McAlester Regional /Zoellner Medical Group staff members do not provide assistance. If you require assistance getting in and out of bed, getting to and from the restroom, or walking you will need to bring a responsible caregiver with you to you scheduled sleep study. (Example: Spouse, appointed caregiver, Friend or Adult child).

Patient Written Name: _____

Patient Signature: _____ Date: _____