OCH REGIONAL MEDICAL CENTER

ANCILLARY SERVICES (LAB, RADIOLOGY AND OCH CLINICS)

Patient Name:
Date of Birth:
Account Number:

Fall Risk Prevention Program

Please help us determine if you are at risk for a fall.

Can you say **YES** to any of these questions?

1. Have you fallen in the last 6 months (please circle)?

   ☐ **YES** ☐ **NO**

2. Do you have any difficulty walking or do you use a walking cane, walker, crutches, or wheelchair (please circle)?

   ☐ **YES** ☐ **NO**

3. Are you experiencing any dizziness or weakness (please circle)?

   ☐ **YES** ☐ **NO**

4. Do you have any problems with your vision that are **not** corrected with glasses or contacts (please circle)?

   ☐ **YES** ☐ **NO**

Signature: _____ Date: _____

☐ Patient ☐ Patient Representative ☐ Staff