

Patient Name:	
Date of Birth:	
Account Number:	

ANCILLARY SERVICES (LAB, RADIOLOGY AND OCH CLINICS)	Account Aumoer.	
AND OCH CLINICS)		
<u>Fall Risk Pre</u>	vention Program	
Please help us determine	e if you are at risk for a fall.	
Can you say <u>YES</u>	to any of these questions?	
1. Have you fallen in th	ne last 6 months (please circle)?	
YES	NO	
•	ficulty walking or do you use a walking es, or wheelchair (please circle)?	
YES	NO	
3. Are you experiencing circle)?	g any dizziness or weakness (please	
YES	NO	
	blems with your vision that are <b>not</b> es or contacts (please circle)?	
YES	NO	
Signature:	Date:	
☐ Patient ☐ Patient R	Representative   Staff	

Reference: HPIC Risk Management

Formulated: 10/2017 Revised: 11/17, 12/17 Approved by: Patricia Faver, CCO/CLO Page 1 of 2