ANCILLARY SERVICES
(LAB, RADIOLOGY
AND OCH CLINICS)

Patient Name:

Date of Birth:

Account Number:

OCH Pulmonology and Sleep Center

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