Fall Prevention – Clinical Audit

Patient name or initials: _____

GP name and practice name: _____

Initial audit (Date: _____)

GP fall risk assessment and tailored intervention(s) to fall risk factor(s)		
Fall risk factors	**Currently undertaking**	**Recommended**
☐ 1 fall in past year ☐ Multiple falls in past year ☐ Injurious fall(s) ☐ Problems with balance/strength/gait ☐ Psychotropic medications ☐ Polypharmacy ☐ Severe vision impairment ☐ Cataract ☐ Postural hypotension/dizziness ☐ Disabling foot pain ☐ Urge incontinence ☐ Recent hospitalisation ☐ Cognitive impairment	☐ Balance and lower limb strength training: ☐ Community exercises (with balance component) ☐ Physiotherapist ☐ Exercise physiologist ☐ Fall prevention program ☐ Home safety review by an occupational therapist ☐ Falls clinic ☐ Medication review ☐ Cataract removal surgery ☐ Others:	☐ Balance and lower limb strength training: ☐ Community exercises (with balance component) ☐ Physiotherapist ☐ Exercise physiologist ☐ Fall prevention program ☐ Home safety review by an occupational therapist ☐ Falls clinic ☐ Medication review ☐ Cataract removal surgery ☐ Others:

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Post audit (Date: _____)

Review of uptake of fall prevention recommendations	
Recommendation uptake review	**Comments (e.g. changes made as a result, patient report of benefits, barriers, recommendations to follow up)**
☐ Balance and lower limb strength training: ☐ Community exercises (with balance component) ☐ Physiotherapist ☐ Exercise physiologist ☐ Fall prevention program ☐ Home safety review by an occupational therapist ☐ Falls clinic ☐ Medication review ☐ Cataract removal surgery ☐ Others:	

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