Alzheimer's
— In Your Home —
AlzheimersInYourHome.com

AFTER FALL INVESTIGATION FORM

Every fall has a story.
Let's learn from it to help prevent the next one.

CAREGIVER PEARL

You may not remember every detail of a fall, but writing it down today can provide important answers tomorrow.

Loved One's Name: _____ **Date of Fall:** _____

Caregiver Completing Form: _____ **Time of Fall:** _____ ☐ AM ☐ PM

1 WHERE DID THE FALL HAPPEN?

- ☐ Bedroom
- ☐ Bathroom
- ☐ Living Room
- ☐ Kitchen
- ☐ Hallway / Stairs
- ☐ Outside
- ☐ Other: _____

Specific Location:

_____

_____

2 WHAT WAS YOUR LOVED ONE DOING?

- ☐ Walking / Moving
- ☐ Getting up from: _____
- ☐ Going to the bathroom
- ☐ Coming from the bathroom
- ☐ Reaching for something
- ☐ Turning
- ☐ Climbing
- ☐ Rushing
- ☐ Other: _____

Please describe what happened:

_____

_____

3 WHAT DO YOU THINK CAUSED THE FALL?

- ☐ Tripped over object
- ☐ Poor lighting
- ☐ Wet / slippery floor
- ☐ Uneven surface
- ☐ Loose rug / carpet
- ☐ Footwear
- ☐ Dizziness / lightheaded
- ☐ Weakness
- ☐ Rushed
- ☐ Did not use walker / cane
- ☐ Other: _____

Other Details:

_____

_____

4 INJURIES OBSERVED

- ☐ No visible injury
- ☐ Bruise
- ☐ Cut
- ☐ Skin tear
- ☐ Swelling
- ☐ Possible broken bone
- ☐ Hit head
- ☐ Pain (location): _____
- ☐ Other: _____

Describe Injuries:

_____

_____

5 WHAT WAS YOUR LOVED ONE WEARING?

- ☐ Socks
- ☐ Shoes
- ☐ Slippers
- ☐ Barefoot
- ☐ Other: _____

Comments:

_____

_____

6 WHAT ACTION WAS TAKEN?

- ☐ Stayed on the floor
- ☐ Helped up by caregiver
- ☐ Helped up by other person
- ☐ Medical help called (911)
- ☐ Doctor / Urgent Care
- ☐ ER / Hospital
- ☐ No medical help
- ☐ Other: _____

Details:

_____

_____

7 CHANGES AFTER THE FALL?

- ☐ Increased confusion
- ☐ Sleepy / drowsy
- ☐ More agitated
- ☐ Pain
- ☐ Difficulty walking
- ☐ Loss of appetite
- ☐ None
- ☐ Other: _____

Describe Changes:

_____

_____

8 FOLLOW-UP

Doctor Notified: ☐ Yes ☐ No Date: _____

Notes / Instructions Given: _____

_____

_____

Next Steps: _____

_____

_____

LOOKING FOR PATTERNS

Has your loved one had other falls recently?

☐ Yes ☐ No If yes, how many in the past 6 months? _____

Are there patterns you've noticed?

_____

_____

_____

TIPS:

- ○ Review this form after each fall.
- ○ Look for patterns or changes.
- ○ Share this information with your loved one's healthcare provider.
- ○ Use this form to help make your home safer.