


# FALLS RISK PROFILE FOR AMPUTEES

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Gender: M / F NHS Number : \_\_\_\_\_

Increased Falls Risk	Patient Profile	Action (Date & Initials once completed)
1. No of falls since amputation <input type="checkbox"/> 2. No of falls in 12 months prior to amputation <input type="checkbox"/> 3. Advise patient of potential types of falls & interventions to reduce risk 4. Phantom sensation	Description of fall(s):  Y / N Y/N	
4. No of fractures since 50 <input type="checkbox"/> 5. Osteoporosis risk factors? Y / N (See checklist to right: >3 = risk) 6. Osteoporosis Medication? Y / N (i.e. Adcal D3 and Bisphosphonates) 7. Vitamin D risk? (>6/52 indoors) Y / N	Wrist / Vertebrae / Hip / Ankle / Other Details: Female / Previous fragility # / Smoking History / Family History / Menopause below 40 / Renal History / Long term steroid use / Significant height loss / Thyroid Treatment / Previous Cancer treatment If not on medication but at risk, a bone health review is needed. If yes, calcium and vitamin D status review needed.	
8. No of medications in total <input type="checkbox"/> (Please circle category of drugs taken →) 9. More than 4 meds? Y / N	Sedatives/ Night Sedatives / Opiates / Diuretics Psychotropics / Cardiac Drugs / Antihypertensives	
10. BP Lying to Standing Postural Drop >20 mmHg? Y / N	Lying: _____ Standing: _____	
11. Concerned about falling? Y / N 12. Ability to get off the floor?	0 1 2 3 4 5 6 7 8 9 10 (0= no fear, 10= terrified) If so, why? Able / Unable / Unsure Details:	
13. Wheelchair mobility? Y / N 14. Wheelchair transfers? Y / N 15. Mobility/Walking Aids with prosthesis?	Independent / Supervision / Assistance Independent / Supervision / Assistance None / Stick x1 / Stick x2 / Quad stick / Frame Details:	
16. Other relevant factors: 17. Query UTI? Y / N (see checklist to right)	Dementia? Y / N      Poor memory? Y / N Recent deterioration in vision? Y / N → In hearing? Y / N Low Mood? Y / N      Call bell within reach Y / N Continence issues? Y / N      Urinalysis completed Y / N <u>Query UTI:</u> Burning / Stinging / Frequency / Confusion / Urine Sample Positive	Over 70yr – MMSE =
18. Other relevant medical history:	History of dizziness/blackouts? Y / N History of cardiac events? Y / N History of EtOH? Y / N Diabetic ? Y / N	BMs =
19. Foot Problems? Y / N Nails / Skin / Corn / Callus / Other Details: 20. Problematic Footwear? Y / N Details:		

**\*\* Please do not leave any part of this form blank.**

Completed by: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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