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Post Polio Falls Screening Checklist

Falls History

	YES	NO	ACTION PLAN
Have you experienced a fall or near fall within the last year?			
If yes, did your fall occur within the home?			
Can you transfer out of a chair without using your arms?			
Do you limit or avoid engagement in activities as a result of fear of losing balance and/ or falling?			
Do you rely on walking aids?			
If yes, are you confident that you are using your walking aids correctly?			
Have you engaged in falls prevention in the past?			

Medical History

	YES	NO	ACTION PLAN
Do you feel unbalanced when standing and/ or walking?			
Do you experience weakness in one side of your body more than the other?			
Have you experienced a decline in strength, coordination, and/ or sensation within the lower limbs?			
Have you developed an abnormal walking pattern?			
Are you aware of the possible side effects your regular medications can cause?			
Do you experience any dizziness and/ or light-headedness throughout your day?			
Are you aware of any cognitive challenges such as, inattentiveness?			
Have you had an eye exam within the last year?			
Do you experience incontinence or urgency problems?			
Are you aware of any heart problems, such as rhythm and/ or heart rate?			
Do you have or had a past history with depression?			
Are you aware of any known risk factors and/ or medical conditions that pose a falls risk?			

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Falls risk within the home

	YES	NO	ACTION PLAN
Are steps, flooring and flooring covers well maintained and secured?			
Are all rugs in good condition and are non-slip and/ or secured to the floor?			
Does the current arrangement of furniture keep walkways clear?			
Are all walkways and stairs kept free of clutter?			
Are all electrical cords and wires kept secured and away from walkways?			

LIVING AREA	YES	NO	ACTION PLAN
Are you able to transfer in and out of your lounge chair with ease?			
When sitting in your lounge chair are you able to safely reach the telephone/ cellphone?			

KITCHEN	YES	NO	ACTION PLAN
Are you able to clean up spills timely after they happen?			
Are you able to reach regularly used kitchen items with ease?			

BATHROOM AND TOILET	YES	NO	ACTION PLAN
Are you able to transfer on and off the toilet with ease?			
Are you able to transfer in and out of the shower and/ or bath independently?			
If not, are there handrails installed in your shower and/ or bath to aid with transfers?			
Do you have slip-resistant mats located in your bathroom?			
Are your shower and/ or bath soaps, washes and towel easy to reach?			
Is the passageway between the toilet and bathroom well lit?			

BEDROOM	YES	NO	ACTION PLAN
Are you able to transfer in and out of bed with ease?			
Are you able to reach the light switch and if applicable glasses safely from bed?			
Is there a telephone located in the bedroom?			
Are you able to safely get to the toilet at night without rushing?			

STAIRS AND HALLWAYS	YES	NO	ACTION PLAN
Are stairs and/ or hallways well-lit, with a light switch at top and bottom of stairs?			
Are stairs equipped with secure and easy to reach handrails?			
Are there non-slip coverings on stairs?			

FALLS RISK OUTSIDE THE HOME

	YES	NO	ACTION PLAN
Are steps equipped with sturdy easy-to-grip handrails?			
Is the edge of steps clearly marked?			
Are footpaths in good condition and well-lit?			
If applicable, are icy footpaths equipped with handrails and/ or sand/ salt?			

PERSONAL SAFETY

	YES	NO	ACTION PLAN
Do you wear well-fitting and supportive shoes inside and out of the home?			
Do you wear shoes with an appropriate heel?			
Are your slippers well-fitted, supportive and have non-slip soles?			
Do you have regular check-ups with your doctor?			
Do you know how to get up from a fall?			
Do you have a medical alarm?			