MemorialCare™
Orange Coast Medical Center

OUTPATIENT REHABILITATION DEPARTMENT

OTHER PATIENT INFORMATION

- ***Psychosocial Issues:***

Has anyone physically harmed you in any way in the past three months? ☐ Yes ☐ No

In your home environment, do you feel: ☐ Safe or ☐ Unsafe

The undersigned certifies that he/she has provided the most accurate information above, and is a patient or the patient's legal representative authorized by the patient.

Patient Signature:____Date:____________________________

Therapist Only:

Issues / Barriers Affecting Learning:

☐ None
☐ Language
☐ Deafness
☐ Religious Beliefs
☐ Desire / Motivation
☐ Physical Needs
☐ Cultural Values
☐ Cognitive
☐ Inability to Read
☐ Other:

Plan of Action to Address Barriers:

____

____

Fall Risk Factor:	**Score**
☐ Gait disturbance/unsteady gait	4
☐ Incontinent/Nocturia	3
☐ Confused at all times	3
☐ Dizziness/Syncope	3
☐ Intermittent confusion	2
☐ Generalized weakness	2
☐ Previous fall within 12 months	2
☐ Osteoporosis	1
☐ Hearing or visually impaired	1
☐ 70 years old or greater	1
☐ High risk drugs (diuretics, narcotics,sedatives, anti-hypertensives, anti-psychotics, anti-depressants)	2

Total Score: ________**

****A score of 4 or more = initiate fall risk precautions**

Therapist Signature:____ **Date:** ______________________