FALLS/MOBILITY PROBLEMS - Follow-up Visit

PATIENT LABEL

Revised 3/2/09

Reason for Visit: ☐ Prior fall ☐ Fear of falling/gait problem

History:

Progress since last visit: _____

_____

_____

	YES	NO
Able to complete treatment plan?	☐	☐ → _____
Medications unchanged since last visit?	☐	☐ → _____

				YES	NO
Fall since last visit? If yes, circumstances:	☐	☐	Currently uses device for mobility?		
Loss of consciousness……	☐	☐	Cane……	☐	☐
Tripped/stumbled over something..	☐	☐	Walker……	☐	☐
Lightheadedness / palpitations…….	☐	☐	Wheelchair……	☐	☐
Unable to get up within 5 minutes	☐	☐	2 or more drinks alcohol per day……	☐	☐
Needed assistance to get up……	☐	☐	Noticed recent vision change……	☐	☐
Knee or hip pain……	☐	☐	Eye exam since last visit……	☐	☐

Examination: T: ____ P: ____ ☐ Reg R: ____

☐ NAD ☐ Irreg

Chest:	ABNL	NL
Respiratory effort: _____	☐	☐
Lung auscultation: _____	☐	☐
Cardiovascular:		
Cardiac auscultation: _____	☐	☐

LE edema: _____ ☐ YES ☐ NO

Orthostatics:

Lying: BP: _____ / _____ Pulse: _____

Standing: BP: _____ / _____ Pulse: _____

Gait: ☐ ABNL ☐ NL

Abnormal if: -Hesitant start -Broad-based gait -Extended arms -Path deviates -Heels do not clear toes of other foot -Heels do not clear floor

Timed-Up-and-Go: ____sec *(Normal ≤ 15 sec)*

Balance:	YES	NO
Side-by-side, stable 10 sec….	☐	☐
Semi-tandem, stable 10 sec…	☐	☐
Full tandem, stable 10 sec…..	☐	☐

If indicated:	YES	NO
Can pick up penny off floor……..	☐	☐
Resistance to nudge……	☐	☐

-Stand from chair NOT using arms,
-Walk 10 feet,
-Turn around,
-Walk back,
-Sit down

Neuromuscular:	YES	NO
Quad strength:		
Can rise from chair w/o using arms	☐	☐
Normal hip range of motion……...	☐	☐
If indicated: knee exam:		

	YES	NO
Rigidity *(e.g., cogwheeling)*...	☐	☐
Bradykinesia……	☐	☐
Tremor……	☐	☐

Test results:

	ABNL	NL
EKG: _____	☐	☐
Bone mineral density: _____	☐	☐
(OH) Vitamin D level: _____	☐	☐
Holter: _____	☐	☐
Other _____	☐	☐

Impression:

☐ Strength problem ☐ Balance problem ☐ Gait problem ☐ Parkinsonism ☐ Severe hip/knee OA ☐ Other: _____

Status: ☐ Resolved ☐ Improving ☐ Unchanged ☐ Worse

Revised treatment:

☐ Exercises: ☐ Upper body ☐ Lower body
☐ Community exercise program referral
☐ Home safety checklist given
☐ Community resource list given
☐ "Falls" handout
☐ Footwear discussion/handout
☐ Vitamin D 800 IU/day or ____ IU/day
☐ Ca carbonate 1200-1500 mg/day (Ca citrate if on PPI)
☐ Referral for PT
☐ Assistive device: _____ ☐ New ☐ Current device reviewed
☐ Referral for home safety inspection/modifications
☐ Change in medication(s): _____
☐ Referral for eye exam
☐ Cardiology consult
☐ Neurology consult
☐ Other: _____

Other instructions: _____

_____

Follow up: ☐ within _____ Provider's Signature_____ Date_____