Centre intégré
de santé
et de services sociaux
de la Montérégie-Ouest
Québec

Installation : ___________________________

Dossier : ___________

Nom, Prénom : ___________

Date de naissance : ___________ ☐ F ☐ M
aaaa-mm-jj

NAM : ___________ Exp. ___________
aaaa-mm

Nom, Prénom de la mère : ___________

IDENTIFICATION OF FALL RISK AMBULATORY PATIENTS AGE 65 AND OVER

Questions for the user	Yes	No
1. Have you fallen at least once in the past year? How many times have you fallen?	☐	☐
2. Do you have trouble walking or keeping your balance? Explain :	☐	☐
3. Do you worry about falling?	☐	☐

Comments:

____

____

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Filled out by: ___________________________ Date: YYYY-MM-DD
(block letters)

Please return the form to the healthcare professional

Follow-up by the healthcare professional
If the user answered yes to two or more questions: • Tell the user to contact his/her attending physician • Give the patient the brochure about preventing falls

Healthcare professional's signature and title: ___________________________ Date: YYYY-MM-DD