

(Affix Patient ID Label)

UR No \_\_\_\_\_

Surname: \_\_\_\_\_

Given Name \_\_\_\_\_

DOB \_\_\_\_\_

## **Falls Risk for Older People in the Community (FROP-Com) Screen**

Screen all people aged 65 years and older (50 years and older Aboriginal & Torres Strait Islander peoples)

Date of screen:     /     /

FALLS HISTORY		SCORE
1. Number of falls in the past 12 months?	<ul style="list-style-type: none"><li><input type="radio"/> None (0)</li><li><input type="radio"/> 1 fall (1)</li><li><input type="radio"/> 2 falls (2)</li><li><input type="radio"/> 3 or more (3)</li></ul>	[   ]
FUNCTION: ADL status		
2. Prior to this fall, how much assistance was the individual requiring for instrumental activities of daily living (eg cooking, housework, laundry)?  • If no fall in last 12 months, rate current function	<ul style="list-style-type: none"><li><input type="radio"/> None (completely independent) (0)</li><li><input type="radio"/> Supervision (1)</li><li><input type="radio"/> Some assistance required (2)</li><li><input type="radio"/> Completely dependent (3)</li></ul>	[   ]
BALANCE		
3. When walking and turning, does the person appear unsteady or at risk of losing their balance?  • Observe the person standing, walking a few metres, turning and sitting. If the person uses an aid observe the person with the aid. Do not base on self-report. • If level fluctuates, tick the most unsteady rating. If the person is unable to walk due to injury, score as 3.	<ul style="list-style-type: none"><li><input type="radio"/> No unsteadiness observed (0)</li><li><input type="radio"/> Yes, minimally unsteady (1)</li><li><input type="radio"/> Yes, moderately unsteady (needs supervision) (2)</li><li><input type="radio"/> Yes, consistently and severely unsteady (needs constant hands on assistance) (3)</li></ul>	[   ]

**Total Risk Score**

[   ]

Total score	0	1	2	3	4	5	6	7	8	9
Risk of being a faller	0.25		0.7		1.4		4.0		7.7	
Grading of falls risk	0 - 3 Low risk				4 – 9 High risk					
Recommended actions	Further assessment and management if functional/balance problem identified (score of one or higher)				Perform the Full FROP-Com assessment and / or corresponding management recommendations					

Date:     /     /

Name \_\_\_\_\_

Signature \_\_\_\_\_

Designation \_\_\_\_\_