Fall Risk Assessment & Screening Tool (FRAST) ©

Directions: For each question, please check the box with the response that best represents you today. Whenever your responses are in the high or medium risk column, we strongly encourage you to discuss the recommended actions in the last column with your health care provider. Please fill in your initials, year of birth and age on each page. Thank you.

RISK FACTOR	LOW RISK = 0	MEDIUM RISK = 1	HIGH RISK = 2	ACTION RECOMMENDED
1. As of today, my age is _____.	Below 65 years old.	Between 65 and 75 years old.	Over 75 years old.	Attending a fall prevention program may be recommended to lower your fall risk.
2. My gender is _____ .		Male	Female	
3. A fall is any event that led to an unplanned, unexpected contact with a supporting surface such as the floor. Have you fallen?	No, I have not fallen.	In the past six months, I have fallen only once and was NOT injured.	In the past 6 months I have fallen 2 or more times, OR In the past 2 years, I have fallen and been injured requiring medical attention.	People who have had falls or have balance issues are at greater risk for more falls. Your doctor may recommend a: 1. Full annual physical exam 2. Fall prevention program 3. PT[1] evaluation for balance 4. PT or OT[2] evaluation of home 5. PT or podiatrist evaluation of footwear 6. Home fall alarm system
4. How would you describe your daily physical activity level? This might be walking, an exercise class, working out at the gym, swimming or dancing. When you are active, your heart works harder and your breathing gets deeper.	I am engaged in exercise or moderate physical activity 30 min /day, 5-7 days/week.	I am engaged in exercise or moderate physical activity at least 15 min/day, 2-4 times/week.	I am generally not active and do not do exercise that makes my heart rate or breathing increase.	Your doctor may feel that you should begin to exercise, but before you do, s/he might suggest a physical therapy referral to design a safe, individualized program that meets your needs safely.
5. How many prescription medicines do you take?	I have not been prescribed any medications.	I currently take at least one but not more than 4 prescription medications.	I currently take 5 or more prescription medications.	It is recommend that 1. Your doctor and/or pharmacist review your medications carefully 2. You use a weekly pill dispenser to avoid mistakes 3. You keep a list of your medicines

Your Initials: _____Year of Birth: _____ Age Today: _____

[1] Physical Therapist, [2] Occupational Therapist, [3] Ear, Nose & Throat doctor

RISK FACTOR	LOW RISK = 0	MEDIUM RISK = 1	HIGH RISK = 2	ACTION RECOMMENDED
6. In regard to your eye care, please choose the best answer:	I see my eye doctor at least once/year.	I have seen an eye doctor once in the past 2 years.	I have not seen an eye doctor in the past 3 years.	Your doctor may refer you to an eye doctor for an annual exam and to discuss vision care options.
7. In regard to your glasses or contacts, please choose the best answer	I do not wear glasses or contacts.	I wear single-vision glasses or contact lenses (not bifocals or progressive lenses).	I wear multifocal lenses or contacts.	Your doctor may refer you to an eye doctor for an annual exam and to discuss vision care options. Please Note: Multifocal lenses (bifocals, progressive lenses, etc.) may increase fall risk.
8. Do you ever get dizzy?	No, I do not have any problem with dizziness.	I occasionally feel dizzy if I get up out of bed fast or when I am ill.	Dizziness is a problem for me.	Your doctor can check to see if your blood pressure drops when you stand up or if there are other medical problems. He/she may also recommend PT, audiologist or ENT[3] referral.
9. In the past week, have you used any assistive devices (AD) to walk? Assistive devices include canes, quad canes, and/or walkers.	No I don't have an assistive device or need one to walk safely. My doctor has not recommended that I use an assistive device.	I have and correctly use an assistive device that was prescribed for and fit to me. A therapist taught me how to use it correctly.	I use an assistive device but no one has taught me how to use it. **OR** I lean on furniture and walls as I walk by.	If you use an assistive device (AD) or need one, your doctor might want you to see a PT if: 1. You need to begin to use an AD. 2. Yours was not fit for you by a PT. 3. You have not been taught how to use it properly. 4. It has been a long time since a PT fit it and it may now need updating.
10. Choose the group of statements that best describes your overall risk-taking behaviors:	I am careful and seldom take risks. I am not easily distracted. I do not hurry to answer the phone.	Sometimes I do things that later I (or others) think may have been risky.	I refuse to limit myself as I age. I might climb up a ladder or learn a new risky sport.	Remaining active is critical, but sometimes taking risks has greater implications as we age. Discuss your answers with your health provider and seek their advice.
11. In the past week, how socially active have you been?	I come and go often and see others 5-7 days/week and/or I am married.	I see other people 2-4 days/week.	I see other people less than 2 times/week.	Your doctor might advise you to visit with the service coordinator at your Area Agency on Aging and/or Senior Center to learn about programs to assist you.

Your Initials: _____Year of Birth: _____ Age Today: _____

[1] Physical Therapist, [2] Occupational Therapist, [3] Ear, Nose & Throat doctor

RISK FACTOR	LOW RISK = 0	MEDIUM RISK =1	HIGH RISK=2	ACTION RECOMMENDED
12. Please carefully complete the Home Safety Checklist. When you finish, count the total check marks that you made.	I have fewer than 6 check marks.	I have 6-11 checks.	I have more than 11 checks.	It appears that your home is not as safe as it might be. It is important that either an OT or PT make a home visit and help you consider modifications that would make your home safer for you.
13. Please complete the Modified Falls Efficacy Scale. What is your average score? (Add up the score on each of the ten items and then divide the sum by 10)	My average score is 8, 9 or 10.	My average score is between 3 and 7.	My average score is 0, 1 or 2.	This score might indicate that your concern about falling is causing you to limit your activities. Your doctor may recommend any or all of the following: 1. Group fall prevention program. 2. Physical therapy referral. 3. Referral to a counselor/social worker.
14. Please complete the Mood Scale and then score it following the directions on the bottom	I scored between 0 and 5 on the mood scale.	I scored 6,7 or 8.	I scored 9 or above.	Your doctor may want to discuss a number of options with you to help improve your mood.
15. Please complete the TUG test (timed-up-and-go).©	My TUG score was 7 seconds or less.	I scored between 8-13 sec. on my TUG test.	My TUG test score was greater than 13 sec.	The TUG test is a test for balance and mobility. If your time is longer, your doctor may want to have you see a physical therapist.
TOTAL SCORE			**___ out of 30**	

Scoring: 0-4 = low fall risk; 5 and above: recommend review with your PCP.

Test reviewed and discussed with client. The following actions have been suggested: _____

Total Score/ Fall Risk Rating: ___ out of 30 Fall Risk: Low Risk or High Fall Risk

Printed Name/Signature/credentials/Date: _____

Your Initials: _____Year of Birth: _____ Age Today: _____

[1] Physical Therapist, [2] Occupational Therapist, [3] Ear, Nose & Throat doctor

checklisCDC Home Safety Checklist Table for the FRAST

Directions: Answer each question by checking "yes" or "no" for your home. Check "no" if it does not apply to you.

Question	Yes	No	Suggested Actions from the CDC
1. When you walk through a room, do you have to walk around furniture?			Ask someone to move the furniture so your path is clear.
2. Do you have throw rugs on the floor?			Remove the rugs or use double-sided tape or a non-slip backing so the rugs won't slip.
3. Are there papers, books, towels, shoes, magazines, boxes, blankets, or other objects on the floor?			Pick up things that are on the floor. Always keep objects off the floor.
4. Do you have to walk over or around wires or cords (like lamp, telephone, or extension cords)?			Coil or tape cords and wires next to the wall so you can't trip over them. If needed, have an electrician put in another outlet.
5. **Look at the stairs you use both inside and outside your home. Are there papers, shoes, books, or other objects on the stairs?**			Pick up things on the stairs. Always keep objects off stairs.
6. Are some steps broken or uneven?			Fix loose or uneven steps. Paint a contrasting color on the top edge of all steps so you can see the stairs better. For example, use a light color paint on dark wood.
7. Are you missing a light over the stairway?			Have an electrician put in an overhead light at the top and bottom of the stairs. Improve the lighting in your home. Put in brighter light bulbs. Florescent bulbs are bright and cost less to use.
8. Do you have only one light switch for your stairs (only at the top or at the bottom of the stairs)?			Have an electrician put in a light switch at the top and bottom of the stairs. You can get light switches that glow.
9. Has the stairway light bulb burned out?			Have a friend or family member change the light

Adapted from the CDC Home Safety Checklist found at
http://www.cdc.gov/HomeandRecreationalSafety/Falls/CheckListForSafety.html

			bulb.
Question	**Yes**	**No**	**Suggested Actions from the CDC**
10. Is the carpet on the steps loose or torn?			Make sure the carpet is firmly attached to every step, or remove the carpet and attach non-slip rubber treads to the stairs.
11. Are the handrails loose or broken? Is there a handrail on only one side of the stairs?			Fix loose handrails or put in new ones. Make sure handrails are on both sides of the stairs and are as long as the stairs.
12. Look at your kitchen and eating area. Are the things you use often on high shelves?			Move items in your cabinets. Keep things you use often on the lower shelves (about waist level).
13. Is your step stool unsteady?			If you must use a step stool, get one with a bar to hold on to. Never use a chair as a step stool.
14. Look at all your bathrooms. Is the tub or shower floor slippery?			Put a non–slip rubber mat or self–stick strips on the floor of the tub or shower.
15. Do you need some support when you get in and out of the tub or up from the toilet?			Have a carpenter put grab bars inside the tub and next to the toilet.
16. Look at all your bedrooms. Is the light near the bed hard to reach?			Place a lamp close to the bed where it's easy to reach.
17. Is the path from your bed to the bathroom dark?			Put in a night–light so you can see where you're walking. Some night–lights go on by themselves after dark.
Total Checks in the "yes" Column			

Count up the checks you have made in the "yes" column. Now go back to the FRAST questionnaire and answer Item 12.

Thank you.

Adapted from the CDC Home Safety Checklist found at
http://www.cdc.gov/HomeandRecreationalSafety/Falls/CheckListForSafety.html

The Modified Falls Efficacy Scale

Directions: On a scale of 0 to 10, how confident are you that you can do each of these activities without falling, with 0 meaning "not confident/ not sure at all", 5 being "fairly confident/ fairly sure", and 10 being "completely confident/completely sure"?

Please Note: If you have stopped doing the activity at least partly because of being afraid of falling, score a 0.

If you have stopped an activity purely because of a physical problem, leave that item blank.

If you do not currently do the activity for other reasons, please rate that item based on how you perceive you would rate it if you had to do the activity today.

	Activity	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
1.	Get dressed and undressed											
2.	Prepare a simple meal											
3.	Take a bath or shower											
4.	Get in/out of a chair											
5.	Get in/out of bed											
6.	Answer the door or telephone											
7.	Walk around the inside of your house											
8.	Reach into cabinets or closet											
9.	Light housekeeping											
10.	Simple shopping											
11.	Using public transport											
12.	Crossing roads											
13.	Light gardening or hanging out the washing (rate most commonly performed of these activities)											
14.	Using front or rear steps at home											
	TOTAL ALL COLUMNS											
ADD ALL COLUMN TOTALS AND DIVIDE BY 10 **ENTER THIS NUMBER ON FRAST ITEM 13**												

Adapted from Tinetti et al, 1990; Hill et al, 1996

Mood Scale for the FRAST

Directions: Choose the best answer for how you felt over the past week by placing a check in the correct column.

	Question	Yes	No
1.	Are you basically satisfied with your life?		
2.	Have you dropped many of your activities and interests?		
3.	Do you feel that your life is empty?		
4.	Do you often get bored?		
5.	Are you in good spirits most of the time?		
6.	Are you afraid that something bad is going to happen to you?		
7.	Do you feel happy most of the time?		
8.	Do you often feel helpless?		
9.	Do you prefer to stay at home, rather than going out and doing new things?		
10.	Do you feel you have more problems with memory than most?		
11.	Do you think it is wonderful to be alive?		
12.	Do you feel pretty worthless the way you are now?		
13.	Do you feel full of energy?		
14.	Do you feel that your situation is hopeless?		
15.	Do you think that most people are better off than you are?		
16.	**TOTAL NUMBER OF SHADED BOXES THAT ARE CHECKED**		

Please count how many shaded boxes you have checked. Now return to the FRAST and answer item 14.

Adapted from Yesavage, Brink, and Rose, 1983. J Psychiatr Res 1983: 17: 37-49.

Timed Up and Go (TUG) Test[1,2]

1. Equipment: arm chair, tape measure, tape, stop watch.

2. Begin the test with the subject sitting correctly in a chair with arms, the subject's back should resting on the back of the chair. The chair should be stableand positioned such that it will not move when the subject moves from sitting to standing.

3. Place a piece of tape or other marker on the floor 3 meters away from the chair so that it is easily seen by the subject.

4. Instructions : "On the word *GO* you will stand up, walk to the line on the floor, turn around and walk back to the chair and sit down. Walk at your regular pace.

5. Start timing on the word "*GO*" and stop timing when the subject is seated again correctly in the chair with their back resting on the back of the chair.

6. The subject wears their regular footwear, may use any gait aid that they normally use during ambulation, but may not be assisted by another person. There is no time limit. They may stop and rest (but not sit down) if they need to.

7. Normal healthy elderly usually complete the task in ten seconds or less. Very frail or weak elderly with poor mobility may take 2 minutes or more.

8. The subject should be given a practice trial that is not timed before testing.

9. Results correlate with gait speed, balance, functional level,the ability to go out, and can follow change over time.

10. Interpretation $\leq$ 10 seconds = normal

$\leq$ 20 seconds = good mobility, can go out alone, mobile without a gait aid.

< 30 seconds = problems, cannot go outside alone, requires a gait aid.

A score of more than or equal to fourteen seconds has been shown to indicate high risk of falls.

1. Podsiadlo D, Richardson S. *The Time "Up & Go": A Test of Basic Functional Mobility for Frail Elderly Persons.* Journal of the American Geriatrics Society 1991; 39(2): 142-148
2. Shumway - Cook A, Brauer S, Woollacott M. *Predicting the Probability for Falls in Community-Dwelling Older Adults Using the Timed Up & Go Test. Physical Therapy 2000 Vol 80(9): 896-903.*

Saskatoon Falls Prevention Consortium, Falls Screening and Referral Algorithm, TUG, Saskatoon Falls Prevention consortium, June, 2005