Comprehensive Care Plan for Fall Prevention

Date: [Insert Date]

Patient Name: [Insert Patient Name]

Patient ID: [Insert Patient ID]

Healthcare Provider: [Insert Provider Name]

Facility: [Insert Facility Name]

Purpose

This comprehensive care plan aims to reduce the risk of falls and ensure patient safety.

Assessment

Assessment Date: [Insert Date]

- Medical History: [Insert Relevant Medical History]
- Current Medications: [Insert List of Medications]
- Mobility Level: [Assess and Describe Mobility]
- Sensory Function: [Assess Vision/Hearing]

Goals

- Increase patient awareness of fall risks.
- Improve mobility and strength.
- Ensure a safe living environment.

Interventions

- Provide education on fall prevention techniques.
- Implement a regular exercise program for strength and balance.
- Conduct regular home safety assessments.
- Adjust medications as necessary to reduce dizziness or sedation.

Monitoring and Evaluation

Review and adjust the care plan every [Insert Time Frame], or as needed based on patient progress.

Signature

Healthcare Provider Signature: _____

Date: _____