

GSIS Falls Prevention Assessment List

Name of Assessment/Tool	Type	Description	Equipment Needed	Time	Setting/Population	References
30-Second Chair Stand Test (Included in STEADI Tool Kit)	Leg strength and endurance	Evaluates the client's ability to repetitively sit and stand from a chair without using arms. Client begins by sitting in a chair with arms crossed, resting on the opposite shoulder. For 30 seconds, the client should sit and stand. Below average score indicated high fall risk.	Stopwatch, chair	30 seconds	Adult at risk for falls	Center for Disease Control. STEADI: Stopping Elderly Accidents, Deaths & Injuries. http://www.mainehealth.org/workfiles/STEADI/(1)Provider_Toolkit.pdf
4-Stage balance Test (Included in STEADI Tool Kit)	Static balance	Therapist shows client 4 positions for 10 seconds each. Client will describe and demonstrate each position. Assistive devices should not be used in this test. Positions include standing with feet side by side, placing instep of one foot so it is touching the other, placing one foot in front of the other and standing on one foot.	A stopwatch	40 seconds (10 seconds for each position)	Anyone who is at risk for falls	Center for Disease Control. STEADI: Stopping Elderly Accidents, Deaths & Injuries. http://www.mainehealth.org/workfiles/STEADI/(1)Provider_Toolkit.pdf
Activities-Specific Balance Confidence Scale (ABC)	Fear of Falling/Mobility Confidence	Self-administered or conducted in person or via telephone. Participants indicate level of self-confidence that he/she will not lose balance or become unsteady during 11 various activities.	Assessment form	6-30 minutes	Adults at fall risk	Powell, L.E., & Myers, A.M. (1995). The activities-specific balance confidence (ABC) scale. Journal of Gerontology: MEDICAL SCIENCES, 50A(1), M28-M34. http://web.missouri.edu/~proste/tool/Activities-specific-Balance-Confidence-Scale.rtf
Balance Error Scoring System	Static Postural Stability	Assesses balance/ fall risk during: firm/ ground testing position, standing on foam board, standing on both legs, standing on one leg.	Foam pad, stopwatch, Assessment form	10 minutes	Concussion; Traumatic Brain Injury, any environment	University of North Carolina. Balance Error Scoring System. http://www.sportsconcussion.com/pdf/management/BESSProtocolNATA09.pdf
Balance, Evaluation, Systems Test (BESTest)	Multifactorial Assessment	Assesses fall risk and balance during: Biomechanical constraints, Stability Limits, Transitions/Anticipatory, Reactive, Sensory Orientation and Stability in Gait.	Stop watch, Items for Functional Reach, foam mat, 10 degree incline ramp (at least 2 x 2 ft) to stand on, Stair step, 2 shoe boxes, 5-lb free weight, Firm chair with arms, Masking tape.	6-30 minutes	Adults who are at risk for falls	Horak, F. (2008) Balance Evaluation-System Test. http://bestest.us/BESTest.pdf
Berg Balance Scale	Mobility & Balance Screenings	14-item scale designed to measure balance of older adults in clinical setting.	Ruler, 2 standard chairs (one with arm rests, one without. Footstool or step, stopwatch, 15 feet walkway.	15-20 minutes	Adults at risk for falls	Berg, K.O., Wood-Dauphinee, S.L., Williams, J.L., Maki, B., (1992). Measuring balance in the elderly: validation of an instrument. Can J Public Health, 83(2), S7-S11.

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Brunel Balance Assessment	Functional Balance	Assesses functional balance with a 12-point ordinal scale based on sitting, standing and stepping.	Plinth or suitable seating Ruler Step up block 7.5-10 cm high Stopwatch Tape to mark 5m walkway 2 stools/chairs	10 minutes	Post-stroke. Can be used hospital bedside, treatment area, or client's home.	Tyson, S. F. and DeSouza, L. H. (2004). "Development of the Brunel Balance Assessment: a new measure of balance disability post stroke." <i>Clinical Rehabilitation</i> 18(7): 801-810.
Choice-stepping reaction Time (CSRT)	Mobility & Balance Screenings	Assesses sensorimotor, speed and balance to stepping reaction time to determine predictor of falls. Provides composite measure of fall risk.		Not specified	Adult at risk for falls	Lord, S.R., & Fitzpatrick, R.C. (2000). Choice stepping reaction time: A composite measure of falls risk in older people. <i>Journal of Gerontology: MEDICAL SCIENCES</i> , 56A(10), M627-M632.
Clinical Test of Sensory Organization and Balance (CTSIB)	Tests Sensory Interaction and Balance	Assesses patient's balance under sensory conditions that can cause instability.	Stopwatch, piece of medium density summate Foam, Visual / Vestibular conflict dome and Computerized Dynamic Posturography	6-30 minutes	Children or Adults at fall risk	
Community Balance and Mobility Scale	Mobility & Balance Screenings	Designed for clients who are mobile and functioning at a high level, but have persistent balance problems and are at a risk for falling.	Measured track, access to flight of stairs, stop watch, average size laundry basket, 2 lb and 7 1/2 lb. weights, visual target, bean bag	30-60 minutes	clinic setting	Howe, J., Inness, E., Venturini, A., Williams J.I., Verrier M.C. (2006) The Community Balance and Mobility Scale: A balance measure for individuals with traumatic brain injury. <i>Clinical Rehabilitation</i> , 20, 885-95
Comprehensive Falls Risk Screening Instrument	Multifactorial Assessments	Self report questionnaire that measures fall risk in 5 categories: history of falls, medication management, vision, physical functioning (functional mobility), and home environment.	Writing utensil, Consent form, Participant Information Form, list of common medications, Home Safety Checklist, Tables, 1 chair without arms with seat at roughly 18 inches height.	not specified	Adults at fall risk	Fabre, J.M., Ellis, R., Kosma, M., Moore, D., McCarter, K.S., Wood, R.H. (2010). Development and Validation of the Comprehensive Falls Risk Screening Instrument. <i>Physical and Occupational Therapy in Geriatrics</i> , 28(2): 181-194. doi: 10.3109/02703181003640124

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Dizziness Handicap Inventory	Dizziness and Instability Screening	Determines if client's dizziness and instability is significant enough for fall risk. Self-answered check list.	Writing utensil and checklist	5-15 minutes	Adults experiencing persistent dizziness and instability	Jacobson GP, Newman CW: The development of the Dizziness Handicap Inventory. Arch Otolaryngol Head Neck Surg 1990;116: 424-427
Dynamic Gait Index	Mobility & Balance Screenings	Records gait performance in adults with vestibular dysfunction to assess likelihood of falling in older adults. Consists of 8 tasks: walking, changing gait speeds, walking with head turns in vertical and horizontal planes, stepping over and around an obstacle, and stair ascent and descent. Subject is graded on a 4-point ordinal scale.	Shoobox, Cones, Pre-mark 20' and 5', access to stairs.	15 minutes	Older adults at fall risk	Boulgarides, L.K., McGinty, S.M., Willett, J.A., Barnes, C.W. (2003). Use of clinical and impairment-based tests to predict falls by community-dwelling older adults. Phys Ther, 83(4), 328-339. Asher, I.E. (Ed). (2007). Occupational therapy assessment tools: An annotated index (3rd ed.). Bethesda MD: AOTA Press.
Edmonson Psychiatric Fall Risk Assessment Tool	Fall risk based on nine factors	Intended for daily completion and upon hospital admission. Each criteria in 9 categories correlates to a score. Score over 90 indicates high fall risk. Can be self-answered or based on observation.	Check list, Writing utensil	5-10 minutes	inpatient psychiatric population	Edmonson, D., Robinson, S., & Hughes, L. (2011). Development of the Edmonson Psychiatric Fall Risk Assessment Tool. Journal of Psychosocial Nursing Mental Health Services. 2011 Feb; 49 (2): 29-36.
Elderly Falls Screening Test (EFST)	Multifactorial Assessments	Includes 3 components: self administered questionnaire, observation on gait patterns, self administered risk screening multifactor questionnaire.	Stopwatch, Assessment form	not specified	Community-dwelling elderly, functionally independent older adults	Cwikel, J.G., Fried, V.A., Biderman, A., Galinsky, D., (1988). Validation of a fall-risk screening test, the Elderly Fall Screening Test (EFST), for community-dwelling elderly. Disabil Rehabil, 20(5): 161-167.
Fall Risk Checklist (Included in the STEADI Tool Kit)	Multifactorial Assessments	Patient answered questionnaire. Including Fall history, Medical conditions, Medications, Gait, Strength and Balance, Vision, Postural Hypotension and other risk factors.	Writing utensil and checklist	not specified	Adult at risk for falls	Center for Disease Control. STEADI: Stopping Elderly Accidents, Deaths & Injuries. http://www.mainehealth.org/workfiles/STEADI/(1)Provider_Toolkit.pdf
Fall-risk Screening Test	Multifactorial Assessments	Self administered test in which clients will check which response best represents them.	Writing utensil, assessment form	not specified	Community-dwelling elderly	Tromp, A.M., Pluijm, S.M.F., Smit, J.H., Deeg, D.J.H., Bouter, L.M., & Lips, P. (2001). Fall-risk screening test: A prospective study on predictors for falls in community-dwelling elderly. Journal of Clinical Epidemiology, 54, 837-844.
Falls Behavioral Scale (FaB)	Identify client's awareness of behaviors that will increase their likelihood of falling.	Self-administered or administered by interview.	Assessment form, Writing utensil	5-10 minutes	Client's home	Clemson, L., Cumming, R.G. & Heard, R. (2003). The Falls Behavioural (FaB) Scale for the Older Person. https://quinnipiac.blackboard.com/bbcswebdav/pid-498538-dt-content-rid-1581449_1/courses/OT420_Resource_Bagatell_12FA/FaB_manual_2003.pdf

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Falls Efficacy Scale (FES)	Fear of Falling/Mobility Confidence	Designed to self-assess self-confidence in performing daily activities without falling. Survey containing nonhazardous activities related to perceived self-confidence. Items are rated on a 10-point scale according to respondent's feelings of confidence that he or she can perform activity without falling.	Questionnaire, pen/pencil	Not specified	Older adults with or without a history of fear of falling.	Tinetti, M.E., Richman, D., & Powell, L. (1990). Falls efficacy as a measure of fear of falling. <i>Journal of Gerontology: PSYCHOLOGICAL SCIENCES</i> , 45(6), 239-243. http://www.fallpreventiontaskforce.org/pdf/FallsEfficacyScale.pdf http://www.injuryresearch.bc.ca/publications/repository/falls%20efficacy%20scale.pdf
Falls Prevention Strategy Survey (MS-Specific)	Multifactorial Assessments	Self report that addresses protective behaviors related to fall risk.	Writing utensil, assessment form	not specified	Adults with Multiple Sclerosis	Finlayson, M.L., Peterson, E.W., Fujimoto, K.A. & Plow, M.A. (2009). Rasch validation of the falls prevention strategies survey. <i>Archives of Physical Medicine and Rehabilitation</i> , 90(12): 2039-2046. doi: 10.1016/j.apmr.2009.07.013.
Falls Risk Assessment Tool (FRAT)	Falls Risk in subacute and residential care	Screening tool for sub-acute and residential care. Includes risk factor checklist, fall risk status, and action plan.	Part 1-3 of FRAT pack, pencil	Not specified	sub-acute or residential	Stapleton, C., Hough, P., Bull, K., Hill, K., Greenwood, K., & Oldmeadow, L.(2009). A 4-item falls-risk screening tool for sub-acute and residential care: The first step in falls prevention. <i>Australasian Journal on Ageing</i> 28(3): 139-143)
Five Time Sit to Stand (FTSTS)	Identifying balance dysfunction	Assesses functional lower limb strength and change during transitional movements	Standard height chair, stopwatch or watch with second timer	5 minutes or less	Adults with fall risk	Whitney, S. L., Wrisley, D. M., Marchetti, G. F., Gee, M. A., Redfern, M. S. Furman, J. M., (2005). Clinical measurement of sit-to-stand performance in people with balance disorders: Validity of data for the five-time –sit-to-stand test. <i>Physical Therapy</i> 85(10), 1034 – 1045. http://www.chfwcnny.org/Tools/BroadCaster/Upload/Project13/Docs/Falls_Prevention__Risk_Assessments.pdf
Four Step Square Test	Mobility & Balance Screenings	Assesses client's ability to step over low obstacle and change directions for fall risk.	Stop watch, 4 flat canes	5 minutes or less	Adults with fall risk	Dite, W. and Temple, V. A. (2002). "A clinical test of stepping and change of direction to identify multiple falling older adults." <i>Arch Phys Med Rehabil</i> 83(11): 1566-1571
Fullerton Advanced Balance Scale	Multifactorial Balance Assessment	Instruct patients to demonstrate static and dynamic movements while observing. Patient receives score based on how successful and safely they were able to complete each movement.	Scoring form	6-30 minutes	Adult at risk for falls	California State University, Fullerton. Fullerton Advanced Balance Scale. http://hhd.fullerton.edu/csa/documents/FABScaleScoringFormwithCut-OffValues.pdf
Functional Reach Test	Mobility & Balance Screenings	Single item test to be used as a quick screen for balance problems in older adults.	Yardstick attached to wall	Less than 5 minutes for 3 trials	Older adults at fall risk	Duncan P, Weiner D, Chandler J, et al. Functional reach: a new clinical measure of balance. <i>J of Gerontol</i> 1990; 45: M192-197.

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Get Up & Go	Mobility & Balance Screenings	Assesses balance in elderly population.	Chair	Not specified	Anyont at risk for falls	Mathias, S., Nayak, U.S.L., & Isaacs, B. (1986). Balance in the elderly patients: The "get-up and go" test. Archives of Physical Medicine and Rehabilitation, 67(6), 387-389. http://www.aan.com/practice/guideline/uploads/273.pdf
Hendrich-II Fall Risk Assessment	Falls Risk in Hospitalized Patients	Intended to be used in the acute care setting to identify adults at risk for falls.	Assessment form, chair (for get up and go),writing utensil	Not specified. Designed for quick administration.	Acute care	Hendrich, A. (2013 revised). Fall Risk Assessment for Older Adults: The Hendrich II Fall Risk Model. Try This: Best Practices in Nursing Care to Older Adults, 8: 1-2. http://www.nursingcenter.com/prodev/ce_article.asp?tid=751712 http://consultgerirn.org/uploads/File/trythis/try_this_8.pdf
Home Assessment Profile (HAP)	Environmental	Quantitative home assessment that evaluates functional performance and safety, including risk of falling, in subjects' home environment. Examiner observes individual's mobility through the home in various rooms. Client is asked to demonstrate typical activities. Scoring guidelines are provided for identifying potential hazards.	HAP score sheet, pencil/pen	Not specified	Client's living environment	Chandler, J.M., Duncan, P.W., Weiner, D.K., Studenski, S.A., Special feature: The Home Assessment Profile -- A reliable and valid assessment tool. Topics in Geriatric Rehabilitation 2001; 16(3): 77-88. Asher, I.E. (Ed). (2007). Occupational therapy assessment tools: An annotated index (3rd ed.). Bethesda MD: AOTA Press.
HOME-FAST	Environmental	Screening tool designed identify adults with fall risk and determine if referral for more detailed assessment and intervention is necessary. Self-answered 'yes' or 'no' queations about home environment. Allows for comments after each question.	Assessment form, writing utensil	10-15 minutes	client's home	MacKenzie, L., Byles, J. & Higginbotham, N. (2002). Reliability of the Home Falls and Accidents Screening Tool (HOME FAST) for identifying older people at increased risk of falls. Disability & Rehabilitation 24(5); 266-274.
Home-screen Scale	Environmental	Identify environmental and behavioral risks that increase risk of falls.	Assessment form, writing utensil	Not specified	Client's home	Johnson, M., Cusick, A., & Chang, S. (2001). Home-screen: A short scale to measure fall risk in the home. Public Health Nursing, 18(3), 169-177.
Missouri Alliance for Home Care (MAHC) -10 Fall Risk Assessment	multi-factorial risk assessment	Initial screen for fall risk. Self answered questionnaire or taken from medical records. Each question answered 'yes' is 1 point.	Checklist, pencil/pen	Not specified	Client's home	Calys, M., Gagnon, K., & Jernigan, S. (2012). A validation study of the missouri alliance for home care fall risk assessment tool. Home Practice Care Management. doi: 10.1177/1084822312457942

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Morse Fall Scale	Falls Risk in Hospitalized Patients	Very quick and simple way to assess patient's risk and likelihood for falling.	Assessment form, Writing utensil	Under 3 minutes	Acute care, Long term care for any adult at fall risk or after fall	Morse, J.M., Morse, R.M., & Tylko, S.J. (1989). Development of a scale to identify the fall-prone patient. <i>Canadian Journal on Aging</i> , 8, 366-377. Morse, J.M. Preventing patient falls. Thousand Oaks, CA: 1996 Sage Publications. http://www.patientsafety.gov/SafetyTopics/fallstoolkit/
Multi-Directional Reach Test	Mobility & Balance Screenings	Inexpensive tool designed to measure stability by reach in four directions.	yardstick affixed to telescoping tripod	Not specified	Adult at risk for falls	Newton, R.A. (2001). Validity of the multi-directional reach test: A practical measure for limits of stability in older adults. <i>Journal of Gerontology: MEDICAL SCIENCES</i> , 56A(4), M248-M252.
Personal Risk Factors Fall Prevention Checklist	Identifying fall risk	Self- answered 'yes' or 'no' questions that asks about fall history, medications, fear of falling to determine fall risk.	Check list, Writing utensil (Can be administered online)	Under 5 minutes	Adult at risk for falls	Minnesota Safety Council.(n.d.) Fall Prevention Checklist- Personal Risk Factors. http://www.fallpreventiontaskforce.org/documents/PersonalRiskFactorsChecklist.pdf
Push and Release Test	Balance Screening	Identify clients with instability before they experience fall. Assesses client's correntional response when trying to regain balance.	None	Less than 5 minutes	Adults with potential risk of falls	Jacobs, J. V., Horak, F. B., et al. (2006). "An alternative clinical postural stability test for patients with Parkinson's disease." <i>J Neurol</i> 253(11): 1404-1413.
Single Leg Stance (Eyes Open)	Balance measure	Determines the amplitudte and speed of sway to determine fall risk and ability to maintain balance	Stopwatch	Under 3 minutes	Adults with fall risk without presence of disease	Bohannon, R. W. (2006). Single Limb Stance Times: A Descriptive Meta-Analysis of Data From Individuals at Least 60 Years of Age. <i>Topics in Geriatric Rehabilitation</i> , 22, 1, 70-77. http://www.chfwcn.org/Tools/BroadCaster/Upload/Project13/Docs/Falls_Prevention__Risk_Assessments.pdf
Spartanburg Fall Risk Assessment Tool	Identifying fall risk	Determines predictor of falls for acute care patients		Not specified	acute care population	Robey-Williams, C., Rush, K. L., Bendyk, H., Patton, L. M., Chamberlain, D., & Sparks, T. (2007). Spartanburg fall risk assessment tool: A simple three-step process. <i>Applied Nursing Research</i> , 20(2), 86-93. doi: 10.1016/j.apnr.2006.02.002
STEADI Falls Risk Assessment	Multifactorial Assessments	Can be used for screening, fall risk assessment and care management. self- administered checklist. Tool Kit includes clinican resources and patient education resources.	STEADI Tool Kit, Patient Self-Risk Assessment	Varies depending on portion of assessment	Adults with fall risk	U.S. Centers for Disease Control STEADI Toolkit http://www.cdc.gov/homeandrecreationalsafety/Fall/steady/index.html#download

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STRATIFY	Falls Risk in Hospitalized Patients	Intended to be used in the acute care setting to predict chance of falling.	Assessment form, writing utensil	Not specified.	Acute care, Long term care for any adult at fall risk or after fall	Oliver, D., Britton, M., Seed, P., Martin, F.C., Hopper, A.H. (1997). Development and evaluation of evidence based risk assessment tool (STRATIFY) to predict which elderly inpatients will: case-control and cohort studies [papers]. British Medical Journal, 315(7115), 1049-1053.
Tandem Stance	Balance Screening	Very quick and simple way to assess patient's balance. Client stands heel to toe. Client should shake head (like saying 'no') 10 times. Then shake head up and down (like saying 'yes')	None	1-2 minutes	Anyone who is at risk for fall	Murphy, M.A., Olson, S.L., Protas, E.J., Overby, A.R. Screening for falls in community-dwelling elderly. J Aging Phys Act 2003; 11: 66-80.
Timed Up & Go (TUG)	Mobility & Balance Screenings	The TUG is used to examine functional mobility in community-dwelling, frail older adults. The TUG measures the time (in seconds) the participant takes to stand up from a standard armchair, walk 3 meters, turn, walk back to the chair, and sit down again. A practice trial is given, followed by 2 timed trials which are averaged and compared to normative values.	Arm chair, tape measure, tape, stopwatch	3 minutes or less. Greater than 12 seconds indicates high fall risk	Anyone at risk for falls	Podsiadlo, D., & Richardson, S. (1991). The timed "up & go": A test of basic functional Mobility for frail elderly persons. Journal of the American Geriatrics Society, 39(2), 142-148. Shumway-Cook, A., Brauer, S., & Woollacott, M. (2000). Predicting the probability for falls in community-dwelling older adults using the timed up & go test. Physical Therapy, 80(9), 896-903. http://foxrehab.org/uploads/pdf/2008_AssitedLivingConsult_TUGTest.pdf Mathias, S., Nayak, U.S.L., & Isaacs, B.(1986). Balance in elderly patient" The "Get Up and Go" Test. Arch Phys Med Rehabil (1986)67: 287-389
Tinetti Performance-Oriented Mobility Assessment (POMA)	Mobility & Balance Screenings	Measures gait and balance of older adults to determine mobility status and changes over time. Used to determine fall risk. Subject completes 28 tasks in two functional areas: balance and gait. The examiner observes and scores subject's performance on basis of specified criteria and on 3-point ordinal scale. Individual scores are combined to form three measures: overall gait assessment, overall balance assessment, and combined score.	Hard, armless chair; score sheet, stopwatch, 15 feet walkway	10-15 minutes	Adults at risk for falls	Tinetti, M.E. (1986). Performance-oriented assessment of mobility problems in elderly patients. American Geriatrics Society, 24(2), 119-126. http://web.missouri.edu/~proste/tool/Tinetti-Balance-Gait--POMA.rtf Asher, I.E. (Ed). (2007). Occupational therapy assessment tools: An annotated index (3rd ed.). Bethesda MD: AOTA Press.

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University of Illinois Chicago Fear of Falling Measure (UICFFM)	Fear of Falling/Mobility Confidence	Self- answered rating scale to assess the level of fear of falling.	Assessment form, Writing utensil	Not specified	Community-dwelling elderly	Veloza, C.A., & Peterson, C.W. (2001). Developing meaningful fear of falling measures for community dwelling elderly. <i>American Journal of Physical Medicine & Rehabilitation</i> , 80(9), 662-673.
Westmead Home Safety Assessment	Identify fall hazards and risks in client's home	Inventory or checklist to identify fall risks within client's home.	Assessment form, Writing utensil	60 minutes	Client's home environment	Cooper, B., Letts, L., Rigby, P., Stewart, D., & Strong, S. (2005). Measuring environmental factors. In M. Law, C. Baum, & W. Dunn (Eds.), <i>Measuring occupational performance: Supporting best practice in occupational therapy</i> (2nd ed., pp. 326–327). Thorofare, NJ: Slack.