Morse Fall Scale(17, 18)

Item	Item Score	Patient Score
1. History of falling (immediate or previous)	No 0 Yes 25	_____
2. Secondary diagnosis (≥ 2 medical diagnoses in chart)	No 0 Yes 15	_____
3. Ambulatory aid None/bedrest/nurse assist Crutches/cane/walker Furniture	 0 15 30	_____
4. Intravenous therapy/ heparin lock	No 0 Yes 20	_____
5. Gait Normal/bedrest/wheelchair Weak* Impaired†	 0 10 20	_____
6. Mental status Oriented to own ability Overestimates/forgets limi-tations	 0 15	_____
Total Score‡: Tally the patient score and record. <25: Low risk 25-45: Moderate risk >45: High risk		_____

* Weak gait: Short steps (may shuffle), stooped but able to lift head while walking, may seek support from furniture while walking, but with light touch (for reassurance).

† Impaired gait: Short steps with shuffle; may have difficulty arising from chair; head down; significantly impaired balance, requiring furniture, support person, or walking aid to walk.

‡ Suggested scoring based on Morse JM, Black C, Oberle K, et al. A prospective study to identify the fall-prone patient. Soc Sci Med 1989; 28(1):81-6. However, note that Morse herself said that the appropriate cut-points to distinguish risk should be determined by each institution based on the risk profile of its patients. For details, see Morse JM, , Morse RM, Tylko SJ. Development of a scale to identify the fall-prone patient. Can J Aging 1989;8;366-7.