

Mini-CEX for Falls (Patient Care Domain)

Date: _____	Trainee: _____	PGY Level: _____
Evaluator: _____	Rotation: _____	(circle) Inpt Outpt snf
Skill Assessed (circle): <input type="radio"/> History <input type="radio"/> Physical Exam <input type="radio"/> Gait & Balance Assessment <input type="radio"/> Evaluation		
Ratings (select one): 0=Unsatisfactory; 1=Rudimentary; 2=Competent; 3=Superior/Mastery		
The PRIMARY DIAGNOSIS of the patient examined by the trainee was: _____		

- | | | | | |
|---|---------------------------|--------------------------|---------------------------------|--|
| 1. History-Taking | 0 | 1 | 2 | 3 |
| ❖ Asked about prior falls | <input type="radio"/> yes | <input type="radio"/> no | | |
| ❖ Asked about associated symptoms | <input type="radio"/> yes | <input type="radio"/> no | | |
| ❖ Asked about activity at time of fall | <input type="radio"/> yes | <input type="radio"/> no | | |
| ❖ Asked about location of fall | <input type="radio"/> yes | <input type="radio"/> no | | |
| ❖ Asked about loss of consciousness preceding fall | <input type="radio"/> yes | <input type="radio"/> no | after the fall | <input type="radio"/> yes <input type="radio"/> no |
| ❖ Asked about pain | <input type="radio"/> yes | <input type="radio"/> no | | |
| ❖ Asked about head injury | <input type="radio"/> yes | <input type="radio"/> no | | |
| ❖ Asked about medications patient was taking | <input type="radio"/> yes | <input type="radio"/> no | | |
| ❖ Asked other relevant questions to ascertain fall risk and/or nature of fall | <input type="radio"/> yes | <input type="radio"/> no | | |
| <hr/> | | | | |
| 2. Physical exam | 0 | 1 | 2 | 3 |
| ❖ Checked orthostatic Vital Signs | <input type="radio"/> yes | <input type="radio"/> no | | |
| ❖ Checked for head injury | <input type="radio"/> yes | <input type="radio"/> no | | |
| ❖ Checked for other injury | <input type="radio"/> yes | <input type="radio"/> no | | |
| ❖ Assessed ambulation | <input type="radio"/> yes | <input type="radio"/> no | | |
| ❖ Checked neurologic status | <input type="radio"/> yes | <input type="radio"/> no | | |
| ❖ Performed exam of other relevant systems to assess etiology of fall and/or injury from the fall | <input type="radio"/> yes | <input type="radio"/> no | | |
| <hr/> | | | | |
| 3. Performance-Oriented Gait Assessment (overall) | 0 | 1 | 2 | 3 |
| A. Knowledge of Maneuvers | 0 | 1 | 2 | 3 |
| ❖ Asked patient to sit in, then arise from chair | <input type="radio"/> yes | <input type="radio"/> no | | |
| ❖ Performed sternal nudge – lightly 3X | <input type="radio"/> yes | <input type="radio"/> no | | |
| ❖ Performed Romberg | <input type="radio"/> yes | <input type="radio"/> no | | |
| ❖ Asked patient to walk; observed gait | <input type="radio"/> yes | <input type="radio"/> no | | |
| ❖ Asked patient to turn 360° | <input type="radio"/> yes | <input type="radio"/> no | | |
| ❖ Asked patient to sit down | <input type="radio"/> yes | <input type="radio"/> no | | |
| B. Interpretation of Maneuvers | 0 | 1 | 2 | 3 |
| ❖ Able to calculate Tinetti gait and balance score | <input type="radio"/> yes | <input type="radio"/> no | <input type="radio"/> partially | |
| ❖ Could recognize normal from abnormal stride length, steppage height, arm swing | <input type="radio"/> yes | <input type="radio"/> no | <input type="radio"/> somewhat | <input type="radio"/> not applicable |
| ❖ Could recognize abnormal gait patterns that warrant intervention | <input type="radio"/> yes | <input type="radio"/> no | <input type="radio"/> partially | <input type="radio"/> not applicable |
| <hr/> | | | | |
| 4. Evaluation (overall) | 0 | 1 | 2 | 3 |
| ❖ Performed a medication review/adjusted meds where relevant | <input type="radio"/> yes | <input type="radio"/> no | | |
| ❖ Prescribed appropriate assistive device when indicated | <input type="radio"/> yes | <input type="radio"/> no | | |
| ❖ Assessed future risk of falling | <input type="radio"/> yes | <input type="radio"/> no | | |
| ❖ Counseled patient/family/staff wrt future falls prevention | <input type="radio"/> yes | <input type="radio"/> no | | |
| ❖ Ordered relevant diagnostic tests to assess extent of injury | <input type="radio"/> yes | <input type="radio"/> no | | |

Comments: (Note what the trainee did well, areas in need of improvement, and suggested next steps)

Evaluator Signature: _____