

Morse Fall Scale

Item	Options	Points
History of falling	No	0
	Yes	25
Secondary diagnosis	No	0
	Yes	15
Ambulatory aid	None: None, bed rest or nurse assist	0
	Device: Crutches, cane or walker	15
	Furniture: Grabs furniture to walk	30
IV therapy / IV access	No	0
	Yes	20
Gait	Normal: Normal, bed rest or wheelchair	0
	Weak: Short steps, stooped, light touch on furniture	10
	Impaired: Shuffles, trouble rising, needs support to walk	20
Mental status	Knows own limits: Oriented to own ability	0
	Forgets limits: Overestimates or forgets limitations	15

Interpretation

0–24	Low risk. Low fall risk. Use standard fall precautions, such as a safe room, call light in reach and nonskid footwear.
25–44	Moderate risk. Moderate fall risk. Add fall prevention measures aimed at the factors that scored, per your facility protocol.
45–125	High risk. High fall risk. Start your facility's high-risk fall protocol, such as bed alarm, scheduled toileting, assisted ambulation and close monitoring.

Total score: _____ Date: _____ Assessed by: _____

Janice M. Morse, 1989. Sources: AHRQ Fall Prevention Toolkit: Morse Fall Scale; Morse Fall Scale form with risk levels; ScienceDirect Topics: Morse Fall Scale. Free calculator and full guide: nursingscales.com/morse-fall-scale/ · Educational material; does not replace clinical judgment or facility protocols.