Date: [Date]

Patient Name: [Patient Full Name]
Date of Birth: [DOB]
Address: [Patient Address]

Dear [Patient Name or Family Representative],

As part of your home health nursing services, a Fall Risk Assessment was conducted on [Date of Assessment] by [Nurse Name, RN/LPN]. The purpose of this evaluation is to identify factors that may increase the chance of an accidental fall and to ensure your safety at home.

Assessment Results:

Your current fall risk level has been identified as: **[Low / Moderate / High]**

Key Findings and Recommendations:

- **Physical Factors:** [e.g., Unsteady gait, vision changes, or medication side effects]
- **Environmental Hazards:** [e.g., Loose rugs, poor lighting, or lack of grab bars]
- **Recommended Actions:** [e.g., Use of a walker, installing a shower chair, or removing clutter]

We have updated your Plan of Care to include specific interventions to help prevent falls. Please remember to use your assistive devices at all times and call for assistance if you feel dizzy or weak.

If you have any questions regarding this assessment or the recommended safety measures, please contact our office at [Agency Phone Number].

Sincerely,

[Nurse Signature]
[Nurse Name and Title]
[Home Health Agency Name]