

FRAIL SCALE RISK ASSESSMENT

Patient Name:

Date:

	Question	Scoring	Result
F	<p>FATIGUE</p> <p>In the last four weeks, did you feel tired all or most of the time?</p> <p>A = All or most of the time B = Some, a little or none of the time</p>	<p>A = 1 B = 0</p>	
R	<p>RESISTANCE</p> <p>In the last four weeks, by yourself and not using aids, did you have any difficulty walking up 10 steps without resting?</p>	<p>Yes = 1 No = 0</p>	
A	<p>AMBULATION</p> <p>In the last four weeks, by yourself and not using aids, did you have any difficulty walking 300 metres OR one block?</p>	<p>Yes = 1 No = 0</p>	
I	<p>ILLNESS</p> <p>Did your doctor ever tell you that you have?</p> <p><input type="checkbox"/> Hypertension <input type="checkbox"/> Diabetes <input type="checkbox"/> Cancer (not a minor skin cancer) <input type="checkbox"/> Chronic lung disease <input type="checkbox"/> Have had a heart attack <input type="checkbox"/> Congestive heart failure <input type="checkbox"/> Angina <input type="checkbox"/> Asthma <input type="checkbox"/> Arthritis <input type="checkbox"/> Kidney disease</p>	<p>Total 0 - 4 = 0 5 - 11 = 1</p>	
L	<p>LOSS OF WEIGHT</p> <p>In the past year, have you lost more than 5kg or 5% of your body weight?</p>	<p>Yes = 1 No = 0</p>	
Total score			