Web table 1. Examples of validated tests and tools available for screening and assessment of fall risk

Timed Up and Go Test (TUGT)[10-12] Screening in the Community	
Description	The TUGT measures the time taken for a person to rise from a chair, walk three metres at normal pace with their usual assistive device, turn, return to the chair and sit down.
Criterion	A time of ≥12 seconds indicates increased risk of falling
Time to undertake test	1–2 minutes
Sit-to-Stand Test (STST)[5] Screening in the Community	
Description	The STST provides a measure of lower limb strength, speed and coordination. It involves the time taken to complete five STSTs as fast as possible from a standard height (43 cm) chair.
Criterion	A time of ≥12 seconds indicates increased risk of falling
Time to undertake test	1–2 minutes
Alternate Step Test (AST)[16] - Screening in the Community	
Description	AST provides a measure of lateral stability and involves the time taken to complete eight steps, alternating between left and right foot, as fast as possible onto a step that is 19 cm high and 40 cm deep.
Criterion	A time of ≥10 seconds indicates increased risk of falling
Time to undertake test	1–2 minutes
FROP-Com Screen[17] Screening in the Community	
Description	A three-item fall risk screening tool, developed from the FROP-Com assessment tool. The three items are a history of falls in the past 12 months; observations of steadiness while standing up, walking three metres, turning returning to the chair and sitting down; and self report of need for assistance in performing domestic activities of daily living.
Criterion	A score of >3 indicates increased risk of falling
Time to undertake test	1–2 minutes
Falls Risk Assessment Tool (FRAT)[18] Screening in the Community / Emergency Department	
Description	A five item screen; history of a fall in the previous year; four or more regularly prescribed medications; diagnosis of stroke or Parkinson's disease; self reported problems with balance; and inability to rise from a chair without using arms.
Criterion	A score of 3 or more indicates increased risk of falls
Time to undertake test	1-2 mins
Prevention of Falls in the Elderly Trial (PROFET)[9] Screening in the Emergency Department	
Description	Used in people presenting to ED following a fall. Three simple

	questions which identify people at increased risk of further falls – 1) an additional falls over the past 12 months 2) a fall occurring indoors, 3) inability to get up after a fall
Criterion	Yes to any of the questions should trigger further assessment and intervention
Time to undertake test	1–2 minutes
STRATIFY[19] Screening in the Hospital Setting	
Description	5 item questionnaire with questions relating to falls, cognition, transfer and mobility skills, vision and toileting practice.
Criterion	A score of >2 identifies high risk fallers
Time to undertake test	1-2 minutes
Modified STRATIFY[14] Screening in the Hospital Setting	
Description	6 item weighted questionnaire with questions relating to falls, cognition, transfer and mobility skills, vision and toileting practice.
Criterion	A score of ≥9 identifies high risk fallers
Time to undertake test	1-2 minutes
RACF Fall Screen[15] Screening in the Nursing and Residential Aged Care Setting	
Description	Clinical algorithm based on persons ability to stand unaided, previous falls, medication use and continence status
Criterion	Depending of risk factors identified, outcome will be either high or low risk of falls
Time to undertake test	1-2 minutes

Web Table 2 Examples of validated tests and tools available for assessing fall risk

Performance Oriented Mobility Assessment[20] Assessment in the Community	
Description	The POMA is a simple clinical scale that grades performance on 9 balance and 7 gait items, with items graded from 0-1 or from 0-2. The balance items encompass sitting balance, standing up from a chair, standing balance, ability to withstand a nudge, turning and sitting down. The gait items encompass gait initiation, step length and height, step symmetry and continuity, truck sway, walking path and stance.
Criterion	A score lower than 19 indicates an increased risk of falling.
Time to undertake test	10-15 minutes
Quickscreen[13] Assessment in the Community	

Description	QuickScreen is a risk-assessment tool designed for use by practice and rural nurses, allied health workers and GPs. It allows the clinician to estimate the level of increased fall risk and determine which sensorimotor systems are impaired. The QuickScreen consists of the following measures: previous falls, medication use, vision, peripheral sensation, lower limb strength, balance and coordination. The fall assessment requires minimal equipment: a low-contrast eye chart, a filament for measuring touch sensation, and a small step.
Criterion	A score of 4 or more indicates an increased risk of falling
Time to undertake test	10 minutes
FallScreen — Physiological Profile Assessment[21] Assessment in the Community	
Description	FallScreen is a validated risk-assessment tool that can be linked to evidence-based approaches to interventions. It provides detailed quantitative information on the physiological domains contributing to postural stability. FallScreen contains five items: an assessment of vision, peripheral sensation, lower limb strength, reaction time and body sway. The combined results provide an overall fall risk score whilst results in each physiological domain guide intervention.
Criterion	A score of 1 or more indicates an increased risk of falling
Time to undertake test	15–20 minutes
FROP-Com (Falls Risk for Older People — community version)[17] Assessment in the Community	
Description	The FROP-Com is a detailed fall risk factor assessment tool. It includes 13 risk factors in 26 questions with either dichotomous (0–1) or ordinal (0–3) scoring. A total of these individual scores provides an overall score of fall risk (range 0–60), with higher scores indicative of greater risk. The tool includes guidelines on scoring each risk factor, and evidence-based referral or interventions. No special equipment is required. The full FROP-Com and its guidelines are available at www.mednwh.unimelb.edu.au/research/research_falls_service.htm.
Criterion	A score >18 indicates a high risk of falls
Time to undertake test	10–15 minutes
Predict-FIRST[22] Assessment in the Rehabilitation Setting	
Description	Predict-FIRST is a screening tools validated in rehabilitation wards that provides estimates of absolute risk of falls based on the presence of the following five factors: male gender, CNS medication use, a fall in the past year, need for frequent toileting and inability to do the tandem stance test. No special equipment is required.
Criterion	Risk factors present: 0 = 2%, 1 = 4%, 2 = 9%, 3 = 18%, 4 = 33%, 5 = 52%.
Time to undertake test	< 10 minutes