**Answer sheet**

Patient name:  
NHS no:  

<table>
<thead>
<tr>
<th>5 Check eye movements</th>
<th>Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>There is no need for the patient to wear their glasses. The object of this check is to <strong>see if the patient has double vision or difficulty looking to the side.</strong></td>
<td></td>
</tr>
<tr>
<td>Do you ever get double vision/see two of things?</td>
<td>Yes No</td>
</tr>
<tr>
<td>Do the patient’s eyes look straight?</td>
<td>Yes No</td>
</tr>
<tr>
<td>Do the patient’s eyes jiggle about/not keep still?</td>
<td>Yes No</td>
</tr>
<tr>
<td>Do the patient’s eyes move together to follow pen?</td>
<td>Yes No</td>
</tr>
<tr>
<td>Does the patient complain of double vision during the test?</td>
<td>Yes No</td>
</tr>
</tbody>
</table>

**Next steps**
- Document your concerns and immediate actions in the falls care plan.
- Inform the medical team.

Date and time:  
Signature:  
Print name:  
Designation:  

**Look out! Bedside vision check for falls prevention**