

Referral form for patients who may require further falls management

Name.....	Next of kin / main carer.....
UR or NHS no.....	Relationship.....
Date of birth.....Age.....	Contact tel no.....
Address.....	GP Practice/Name.....
.....M / F	Contact tel no.....
Contact tel no.....	Consultant.....

Has there been a loss of consciousness (syncope) associated with the fall?

(patient will have retrograde amnesia ie unable to remember 'blacking out', "Just found myself on the floor" or unable to remember hitting the floor)?

If "yes" to above question and "no" to all Falls 5 Questions below - **DON'T USE THIS FORM.** Patient needs referral to GP and on to either to a consultant geriatrician or cardiologist.

If "yes" to above question and 3 or more "yes" answers to any of the Falls 5 Questions below complete this form (syncope assessment will be included when seen at Secondary Care Falls Clinic)

FALLS 5 QUESTIONNAIRE		Yes	No
a	Is there a history of any fall in the previous year? (Ask the person/carer)		
b	Is the patient/client on 4 or more medications per day? (Identify number and type of medications)		
c	Does the patient/client have a diagnosis of Stroke / Parkinsons' Disease? (Ask the person/carer)		
d	Does the patient/client report/demonstrate any problems with their balance? (Ask patient/carer / observe)		
e	Is patient/client unable to rise from a chair of knee height? (Ask the person to stand up from a chair of knee height without using their arms)		

(Yes to 3 or less will go to Tier 2 Falls Service or a suitable alternative. Yes to 4 or 5 will go to a Multidisciplinary Clinic in secondary care)

FAX THIS FORM TO RBMS ON fax 611 3326 TOGETHER WITH copy of information regarding current medication and medical history for advice If problems re referral contact the administrator, Fax 217 3059 / tel 217 3061 OR use Choose and Book

BRIEF SUMMARY OF ANY OTHER RELEVANT INFORMATION eg How the fall(s) happened? Any referrals made? Any cognitive impairment (state MTS)?

Has this person previously been assessed at a Falls Clinic? YES NO Don't Know

CONSENT TO REFERRAL OBTAINED: CONSENT TO INCLUSION ON A DATABASE

TRANSPORT: Has own Needs hospital transport Not known

Referred by..... Profession.....

Signature..... Date.....

Agency/Department..... Tel no.....Fax no.....