REFERRAL - FALLS PREVENTION SERVICES

Day Hospital Paul Brown Unit
Extension 4030
Fax 01952 282 873

Princess Royal Hospital
Apley Castle
Telford
TF1 6TF
Tel: 01952 641222

Please tick the appropriate referral route:

☐ **Falls Prevention Clinic** (multifactoral assessment & programme) held at Day Hospital, Paul Brown Unit, PRH

☐ **Falls Prevention exercise group for people with dementia** (groups in south Telford & Newport)

☐ **Lower level falls prevention:**
Red Cross StayWell at home service for support after a fall, confidence building, signposting to community services including support to attend falls prevention exercise in the community.

DATE OF REFERRAL: Short date letter merged **URGENCY** ☐ Urgent ☐ Soon ☐ Routine

Patient Name: Title Calling Name Surname Date of Birth: Date of Birth NHS number: NHS Number Address: Home Full Address (single line) Tel No: Patient Home Telephone	Next of kin details: Name: Address: Tel No:
Referrers profession/position: Name: Address: Tel No:	Registered GP Details: Name: Registered GP Full Name Address: Organisation Full Address (single line) Tel No: Organisation Telephone Number

Reason for referral: (include expectations of referral outcome):

If referral is for falls prevention programme please provide the following information:

1. Relevant past medical history and medication (or enclose list):

See Attached

2. Concerns relating to cognition or any diagnosis of dementia (include AMTS, MMSE, MOCA scores, if known):

3. Additional relevant information including social circumstances and special needs/dietary requirements:

Falls screening questions:

How many falls in the past 12 months?

When was their last fall?

	Y	N
Have they ever attended the Day Hospital? If so, when?	☐	☐
Do they feel dizzy on standing or from getting out of bed in the morning?	☐	☐
Have they ever experienced blackouts or loss of consciousness leading to a fall?	☐	☐
Do they forget to use walking aid due to memory impairment?	☐	☐

Please refer via TRAQS

REFERRAL - FALLS PREVENTION SERVICES

Do they have a neurological illness such as stroke, Parkinson's or dementia?	☐	☐
Do they drink alcohol? If so, how many units per week?	☐	☐
Are they frightened of falling?	☐	☐
Do they feel their confidence has been affected?	☐	☐
Have they had an Occupational Therapy assessment? If so as… ☐ inpatient ☐home assessment state outcome	☐	☐
Have they had an Physiotherapy assessment or treatment? If so as…. ☐ inpatient ☐ outpatient ☐ community state outcome	☐	☐

Transport needs: ☐ Car ☐ Ambulance ☐ Private

Red Cross StayWell at home can provide volunteer transport to 6 community exercise classes or 12 dementia and falls prevention exercise classes.

Mobility:

☐ Walking Independently ☐ Needs Assistance No of Assistants

☐ Immobile Mobility Aids

Access Problems

Has the person consented to the referral ☐ Yes ☐ No (if unable to consent, the patient will have to be accompanied for the duration of the appointment by someone who knows them)

Interpreter required? ☐ Yes ☐ No State type or language

Referrers Signature _____ Profession/position _____

REFERRAL - FALLS PREVENTION SERVICES

NAME: Full Name	**D.O.B:** Date of Birth	**NHS No:** NHS Number

HEALTH STATUS

Height:	Single Code Entry: O/E - height	**Weight:**	Single Code Entry: O/E - weight	**BMI:**	Single Code Entry: Body mass index
BP:	Single Code Entry: Systolic blood pressure / Single Code Entry: Diastolic blood pressure Single Code Entry: O/E - blood pressure reading	**Smoking:**	Single Code Entry: Tobacco consumption	**Alcohol:**	Single Code Entry: Alcohol consumption

***PROBLEMS, MEDICATION & ALLERGIES* - Significant active and past problems, current medication and allergies.**

Problems

Medication

Allergies