

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															
<p>Reason for referral: (include expectations of referral outcome):</p> <p>If referral is for falls prevention programme please provide the following information:</p> <p>1. Relevant past medical history and medication (or enclose list): See Attached</p> <p>2. Concerns relating to cognition or any diagnosis of dementia (include AMTS, MMSE, MOCA scores, if known):</p> <p>3. Additional relevant information including social circumstances and special needs/dietary requirements:</p>																
<p>Falls screening questions:</p> <p>How many falls in the past 12 months? When was their last fall?</p>																
<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 80%;"></th> <th style="width: 10%; text-align: center;">Y</th> <th style="width: 10%; text-align: center;">N</th> </tr> </thead> <tbody> <tr> <td>Have they ever attended the Day Hospital? If so, when?</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Do they feel dizzy on standing or from getting out of bed in the morning?</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Have they ever experienced blackouts or loss of consciousness leading to a fall?</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Do they forget to use walking aid due to memory impairment?</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> </tbody> </table>		Y	N	Have they ever attended the Day Hospital? If so, when?	<input type="checkbox"/>	<input type="checkbox"/>	Do they feel dizzy on standing or from getting out of bed in the morning?	<input type="checkbox"/>	<input type="checkbox"/>	Have they ever experienced blackouts or loss of consciousness leading to a fall?	<input type="checkbox"/>	<input type="checkbox"/>	Do they forget to use walking aid due to memory impairment?	<input type="checkbox"/>	<input type="checkbox"/>	
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Please refer via TRAQS

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

<p>Transport needs: <input type="checkbox"/> Car <input type="checkbox"/> Ambulance <input type="checkbox"/> Private</p> <p>Red Cross StayWell at home can provide volunteer transport to 6 community exercise classes or 12 dementia and falls prevention exercise classes.</p>
<p>Mobility:</p> <p><input type="checkbox"/> Walking Independently <input type="checkbox"/> Needs Assistance No of Assistants</p> <p><input type="checkbox"/> Immobile Mobility Aids</p>
<p>Access Problems</p> <p>Has the person consented to the referral <input type="checkbox"/> Yes <input type="checkbox"/> No (if unable to consent, the patient will have to be accompanied for the duration of the appointment by someone who knows them)</p> <p>Interpreter required? <input type="checkbox"/> Yes <input type="checkbox"/> No State type or language</p>

Referrers Signature _____ Profession/position _____

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