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| **Bromley Falls and Fracture Prevention Service Referral Form** |
| **Criteria:** *Please tick to acknowledge the following have been met:*[ ]  Adults over the age of 18 years [ ]  Registered with a **Bromley General Practitioner**[ ]  Patient has **consented** to the referral [ ]  Patient has the **physical & cognitive** **ability to follow** **a falls prevention programme.**Meets **one** of the following criteria: [ ]  Has had a **recent, unexplained fall**[ ]  Has been identified at **high risk of falling**[ ]  Has had **a recent fragility fracture** (\*low impact: fall from standing height or less)[ ]  Has been identified at **high risk of osteoporosis** |
| **Patient Details** |
| **Surname: Given Name:** |
| Mr [ ]  Mrs [ ]  Miss [ ]  Ms [ ]  Other [ ]  please state : **Ethnicity :**  |
| **DOB:** | **Gender: M / F**  | **NHS Number:** RiO / EMISweb number : |
| **Address:** **Postcode:** **Tel: Home / Mobile / work**  | **Key safe Y / N** **Lives alone? Y / N** **Carers Y / N Informal** [ ]  **Formal** [ ] **Access instructions:** **Is an interpreter required?** **If yes, which language?** |
| **GP Details:** **Surgery name & address:** | **Is the patient housebound? Y / N** **Does the patient live alone? Y / N**  |
| **Next of Kin:** **Relationship to patient:** **Address:** **Postcode:** **Tel:** Home:  Mobile: | **Primary Contact (if different from NOK):****Relationship to patient:** **Address:** **Postcode:** **Tel:** Home: Mobile: |

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| **Please note that all sections will need to be completed to aid timely triage\*** |
| **Clinical Information**  |
| **Past Medical History:** *This can be attached as a separate document* |  |
| **Medication:**  *This can be attached as a separate document* |  |
| **\*Please attach a copy of the discharge summary if recently discharged from hospital – Thank you** |

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| **Screening Questions** |
| Patient is aware of the referral and has consented to this? | [ ]  Yes[ ]  No |
| **Number of falls:***Please provide* ***as much detail as possible*** *by asking the patient the nature of the falls and the activities being conducted at the time of the fall. Please provide outcomes of any relevant investigations / interventions that have taken place. Please state if you have been unable to identify a reason for the falls.* |  |
| Discharged from hospital with a fall or non-conveyed LAS call out due to a fall (within the last 1 month): | [ ]  Yes\*[ ]  No*Please attach a discharge summary to this referral, reason for admission & investigations completed.* |
| Previous fragility fracture\* over age of 50: | [ ]  Yes[ ]  No |
| Would this patient be able to travel to a community clinic independently or with family  | [ ]  Yes [ ]  No*\*Please be aware transport cannot be arranged* |
| To aid us with triaging the referral, please outline any assessment needs that you feel your patient may require: | [ ]  OT – Home Assessment / Functional / Intervention[ ]  PT – Gait / Balance Assessment / Intervention[ ]  Consultant – Unexplained falls (will include a pre-assessment therapy clinic)[ ]  Falls prevention and balance classes (will require a pre-assessment in therapy clinic) |
| Functional Ability*Please provide a brief outline of any assistance required, including aids / equipment:* | Mobility:Transfers: Activities of Daily Living: |
| Please send a copy of the Falls Risk Assessment tool you have completed to identify your patient as being at high risk? What steps/measures have already been taken towards falls prevention?  |  |

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| **Date:**  | **Name of referrer:** |
| **Organisation Name:**  | **Title of professional:** |
| **Contact Address:** | **Telephone:** |
| **Email:** |
| **Please send a copy of this referral and any other relevant documents / assessments / outcome measures to:****Email : bromh.cccpod3refs@nhs.net** **Address** St Paul’s Cray Clinic, Mickleham Road, Orpington BR5 2RJ **Tel No: 0300 330 5777** |