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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** | |