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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 as to 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:**  **Title of professional:** | |
| **Organisation Name:**  **Contact Address:** | | **Telephone:**  **Email:** |
| **Please send a copy of this referral and any other relevant documents / assessments / outcome measures to:**  **Email :** [**bromh.fallsteam@nhs.net**](mailto:bromh.fallsteam@nhs.net)  **Address** St Paul’s Cray Clinic, Mickleham Road, Orpington BR5 2RJ **Tel No: 0300 003 2321** | | |