**Before you refer to the service please read the information below:**

**For patients at Low Risk of falls:** No fall or Single non-injurious fall with no gait or balance problems:

**Primary goal: prevention;** we suggest you give education advice regarding falls prevention and exercise options for general health.

**Consider referral for:** Bromley Healthcarebalance group exercises (Strong and StABLE) **if patient consents to referral.**

**For patients at Intermediate risk of falls:** No fall or single non injurious fall, have gait and/or balance problems. May **not require** specialist falls prevention intervention.

**Goal secondary prevention**: Improve risk factors and give education and advice regarding falls prevention.

**Consider referral for: Bromley Healthcare** balance group exercises (Strong and StABLE) or community based exercises classes (primetime) **if patient consents to referral.**

**If the patient is at High Risk of falls: If Yes to 1 or more of the following:**

The individual has sustained a serious injury as a result of a fall, which required medical treatment (no acute injury). The Individual has had recurrent falls in the last 12 months. The individual cannot get up after a fall without assistance and they do not have the means to call for help (at risk of a long lie)?

The individual has rehabilitation potential and can follow advice/instructions/exercise programme:

**Consider referral to Specialist Falls Prevention Team:**

*Please tick relevant boxes:*

Adult over the age of 18 years and has consented to the referral/is aware of the referral

Registered with a **Bromley General Practitioner**

**If possible: Please supply a copy of the discharge summary and any relevant assessments and outcome measures that have been carried out.**

|  |  |  |  |
| --- | --- | --- | --- |
| **Family Name:** | | | **Given Name:** |
| **DOB:** | | | **NHS Number:** |
| **Address:**  **Postcode:**  **Telephone:**  **Mobile:** | | | **GP Name:**  **Surgery name & address:** |
| **NOK Name:**  **Relationship:**  **Contact number:** |
| **Falls History** | | | |
| **Number of falls in last 12 months: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  *Please provide* ***as much detail as possible*** *as to the* ***nature*** *of the falls:* ***activities being carried out and any symptoms experienced immediately before or at the time of the fall.*** | | | |
| **Past Medical History:** *State all* | | | **Medication:** *State all current meds* |
| **What interventions have you taken towards addressing falls prevention?**  For example; Therapy intervention, Provision of equipment including walking aids, Exercise Programmes – state which exercises provided, Written and Verbal advice –state what you have discussed. | | | |
| **Please state: Reason for referral and Patient centred measureable goals:** | | | |
| **Suspected transient loss of consciousness:** if **65 and over** refer to the Geriatrician Syncope clinic at the PRUH. **64 and under** - If you suspect loss of consciousness: refer to Cardiology Syncope Clinic at the PRUH.  We area therapy led service and are unable to investigate syncope. | **If you are referring for the Strong and StABLE exercise classes**:   * For safety reasons: patients need to be able to travel to the venue, undertake one hour of exercises in standing and be able to stand from sitting (armless chair) safely and independently. Independent toileting is also a requirement. * If you are a Physiotherapist referring for the group, if possible complete a Tinetti outcome measure. For safety reasons, patients should have a Tinetti score of at least 18/28 to attend the group. | | |
| **PLEASE COMPLETE THE FOLLOWING:** | | | |
| **Date:** | | **Department/Healthcare Provider address and contact details:** Please include this information | |
| **Name of referrer:** | | **Title of professional:** | |
| **Signature:** | | | |
| **Please send this referral along with any other relevant documents/assessments/outcome measures (additional information will be gratefully received) to:** [**bromh.bromleyhealthcarereferrals@nhs.net**](mailto:bromh.bromleyhealthcarereferrals@nhs.net)  **Enquiries only:** [**bromh.fallsteam@nhs.net**](mailto:bromh.fallsteam@nhs.net)  **Address** St Pauls Cray Clinic, Mickleham Road, Orpington. BR5 2RJ **Tel No: 0300 330 5777** | | | |