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| **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: |

**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**

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| **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** | |

**\*Please note that all sections will need to be completed to aid timely triage\***

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| **Screening Questions** | |
| Patient is aware of the referral and has consented to this? | Yes  No |
| Number of falls: | Multiple in 1 month  Unexplained fall within last month  2 or more in 6 months  2 or more in 1 year  Near misses / deemed to be at high risk |
| 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 \*Please be aware transport cannot be arranged  No |
| 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.bromleyfalls@nhs.net**](mailto:bromh.bromleyfalls@nhs.net)  **Address** St Paul’s Cray Clinic, Mickleham Road, Orpington BR5 2RJ **Tel No: 0300 003 2321** | | |