HERTFORDSHIRE FALLS LIAISON SERVICE REFERRAL FORM

PATIENT DETAILS	***Details of person referring this patient***
Name: Address: Telephone number: Date of Birth: Ethnicity: Sex:	NHS number: GP name: Address: Telephone number**:** Fax: Email:
Next of kin: Relationship: Address: Telephone number:	Referred by: Occupation: Service name and address: Telephone number: Fax: Email:
Date of Referral	
Is an interpreter required? Yes [ ] No [ ] If yes, which language?	Is transport required? Yes [ ] No [ ]

Does the person have cognitive difficulties? Yes [ ] No [ ]
If yes, has a referral been made to or does person have CMHT/ Psycho-geriatrician input? Please give detailsé é

Type of fall (please put ‘x’ in box**)**

1. **Explained fall** ☐ **Unexplained fall** ☐

Reason for referral

CRYER SCORE

		YES (1)	**NO (0)**	**COMMENT**
1	Is there a history of any fall in the previous year?			
2	Is the patient on 4 or more medications per day?			
3	Does the patient have a diagnosis of Stroke or Parkinson’s disease?			
4	Balance (Needs to hold onto furniture, requires a stick/walker)			
5	Is the patient unable to rise from a chair of knee height? How assessed? (Ask the patient to stand up from a chair of knee height without using their arms)			
6	Alcohol (More than one unit a day)			
7	Memory/comprehension difficulties (Does the person show signs of confusion/being muddled?)			
8	Does the patient complain of blackouts, loss of consciousness or is unable to recollect the mechanism of falls (not due to memory)?			
	Total:			

A score of 4 or more indicates that the patient can be referred

PAST MEDICAL HISTORY

Diabetes [ ]	Parkinsons [ ]	Osteoporosis [ ]	Visual impairment [ ]
Ischemic Heart Disease [ ]	Dementia [ ]	Fracture [ ]	Hearing impairment [ ]
Atrial Fibrillation [ ]	Alzheimerõs [ ]	Knee/Hip replacement [ ]	COPD [ ]
B.P. High/Low [ ]		Pacemaker [ ]	Asthma [ ]
Stroke (TIA) [ ]		Angioplasty [ ]	Shortness of Breath [ ]
Pain in chest on exertion [ ]			Vertigo/Dizziness [ ]

Other

Known infections/ chronic diseases past and present

Do any of the conditions above exclude the person from exercises? Yes [ ] No [ ]
Commenté é

MEDICATION

Drug	Dose	Frequency	Comments

Has the person had a change in medication/review recently? YES [ ] NO [ ] Date:

For PMH and Medications please attach medication information and any further information on a separate sheet if necessary. Please attach any relevant discharge summaries, clinic letters, other correspondence or reports

BONE HEALTH

Previous fragility fracture: ☐Hip ☐ Wrist ☐ Vertebrae

Corticosteroids	☐ Yes ☐ No	Rheumatoid Arthritis	☐ Yes ☐ No	If any positive answers, refer to GP
Parental history of osteoporosis/ hip fracture	☐ Yes ☐ No	Alcohol/smoking	☐ Yes ☐ No	
		Already on bone health treatment	☐ Yes ☐ No	
FRAX score: All:__________	Hip:________	How long:_______		

REFERRALS

Is this person known to or receiving input from any other service? YES [ ] NO [ ]
If yes which Service?

Please tick ✓appropriate box

☐ Strength & Balance Class ☐ Chair based exercises ☐ Falls Clinic

Patient Declaration:

I give my permission for my GP/SW/DN/SN to refer me to the Falls Liaison Service and consent to be contacted by the Falls Liaison Service

Patient Signature: ____

Please send form to Ida Antwi, Clinical Falls Co-ordinator, via Fax 01707 361286 (Safe Haven Fax) Email: ida.antwi@hertfordshire.nhs.uk

Date referral received: **Received by:**