Please fax to 0117 414 9457

North Bristol NHS
NHS Trust

Referral Form for Hospital Medical Falls Assessment
Please do not use for Balance / Exercise Groups

(To be completed by Community Nurses/Community Matrons/REACT/Therapists)

<table>
<tr><td colspan="2">Patient name, address, telephone no.
NHS / Hospital number if known</td><td>Name, address & tel no of next of kin

GP name and surgery:</td></tr>
<tr><td colspan="2">Referral Source
REACT ☐
Community Matron ☐
CNOP ☐
ICT ☐
Physio ☐
Other (please give details):</td><td rowspan="2">Known diagnosis</td></tr>
<tr><td colspan="2">Reason for referral
(please circle)
Syncope
Unexplained Dizziness
Patients with recurrent falls where a cause has not been found despite performing a multi-factorial falls risk assessment or patient is falling despite interventions put in place to manage risks

Please give details:</td></tr>
<tr><td colspan="2"></td><td>Present Medication – please ensure accurate (phone GP)

(Attach additional sheets if necessary)</td></tr>
<tr><td>Risk factors identified
Medication ☐
Vision ☐
Continence ☐
Footwear ☐
Foot pathology ☐
Cognitive impairment ☐
Alcohol ☐
Gait / balance ☐
Pain ☐
Environmental ☐</td><td>Details and interventions</td><td>Primary care services

Referral made to community physiotherapist? Yes No
(Details please)

GP made aware of referral? Yes No
(Details please)</td></tr>
<tr><td colspan="2">Mobility Aids used</td><td>Transport needs:
*Car/2 man amb/Tail lift/own transport
*Delete as appropriate</td></tr>
</table>

Name of referrer: Signature:

Contact details: Date: