**Tayside Falls Service Referral**

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| Name:Date of Birth/CHI:Address: AFFIX LABEL Post code: | Telephone: GP/Practice:Next of kin: |

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| **Level 1 Falls Screen** | **Yes** | **No** | **Don’t Know** |
| Have you fallen more than once in the previous 12 months? |  |  |  |
| Did you have any dizziness/blackouts/loss of consciousness at the time of the fall/s |  |  |  |
| Do you have any difficulties with walking or balance? |  |  |  |
| Are you managing to carry out your usual daily activities following the fall/s |  |  |  |
| Are you afraid of falling? |  |  |  |

**If the answer is ‘yes’ to any of the above, please complete below.**

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| **FALLS HISTORY** *(please give as much information as you can)* |
| Do you use a walking aid? What do you use? |

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| **MEDICAL HISTORY***(please give as much information as you can, eg. Diabetes, epilepsy, cardiac problems, confusion)* |
| **N.B.** Nursing home residents and those with advanced confusion / cognitive impairment should be discussed prior to referral.  |

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| **CURRENT MEDICATION***(please give as much information as you can)* |
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| **CONSENT** |
| I am willing to have a further falls risk assessment if necessary. This may involve a referral to a member of the health care team. I hereby give my permission that details from this assessment may be shared with health care professionals including my GP.Signed:……………………………………………………………. Date:……………………………………\*If the person is unable to sign, a representative must sign indicating verbal consent has been obtained |

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| **REFERRER DETAILS** |
| Name: Designation / Relationship to person:Base: Tel:**WHERE DID YOU HEAR ABOUT THIS SERVICE?** |

**Please send your completed referral form to your local Falls Service**

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| **Angus**Falls Service Co-ordinatorStracathro HospitalBy Brechin, DD9 7QATel: 01356 665170Email: Tay.angusfallsservice@nhs.scot | **Dundee**Falls Co-ordinatorRoyal Victoria Day HospitalJedburgh Road, Dundee, DD2 1SPTel: 01382 423140Email: Tay.dundeefallsreferral@nhs.scot | **Perth & Kinross**Assessment Clinic for the ElderlyPerth Royal InfirmaryPerth, PH1 1NXTel: 01738 473482Email: Tay.pkelderlyassessment@nhs.scot**For self-referral please speak with your GP** **Practice.** |
| **Fife:**  Email:  Fife.icassreferralsfife@nhs.scot |

**Guidance notes for completing the Tayside Falls Service referral form.**

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| **FALLS HISTORY** *(please give as much information as you can)* |
| ***This might include..... beginning to lose balance or stumbling, even if you have not fallen.*** |

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| **MEDICAL HISTORY***(please give as much information as you can, eg. Diabetes, epilepsy, cardiac problems, confusion)* |
| ***Please give a list of any conditions that are known about, or may be listed in a care plan.******Please list any issues such as reduced vision, impaired hearing, communication difficulties.*** |

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| **CURRENT MEDICATION***(please give as much information as you can)* |
| ***Try to give a list if you can. May be found on a prescription, or on a blister pack.*** |

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| **CONSENT** |
| ***If the person is unable to sign, please write “verbal consent given” and date.*** |

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| **REFERRER DETAILS** |
| ***Please complete fully, in case we need to contact you for further information.******Examples of “Designation” may be... carer, GP, community nurse, relative......******Examples of “Source of referral” may be: First Contact Team, Community Alarm, Home carer service (name specific service).......*** |

Please add any additional information that you think we may find useful.

 **REMINDER: CRITERIA FOR REFERRAL**

* Have you fallen more than once in the previous 12 months?

* Do you have any difficulties with your walking or balance? (could include feeling that your balance isn’t quite as good as it should be, or beginning to stumble)
* Are you having difficulty carrying out your usual daily functional activities?
* Are you afraid that you will fall? Are you limiting your social activities because of this?
* Do you experience dizziness / blackouts?