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| **Falls Prevention Team Referral Form (For Non-Physiotherapists)**  **Email your Referral to:** [**LIVEWELL.therapyreferrals@nhs.net**](mailto:LIVEWELL.therapyreferrals@nhs.net) | | |
| **Referral form will be returned if all sections are not completed. This is NOT a referral form for the UHP Consultant Falls Clinic – refer to Devon Formulary** | | |
| Inclusion Criteria  * Aged 55 years and over and a Plymouth resident * Experienced one or more falls in the last 12 months OR near miss falls OR are fearful of falling   **PLUS**   * They are interested to gain benefits from exercise (group and at home self-monitored)   They are independently able to:   * Walk around their own home and outdoors with or without a walking aid * Access the community **without assistance from another person to walk and can access transport** * Undertake activities of daily living (though may be finding them more challenging) * Follow simple instructions and monitor their own effort/challenge |  | Exclusion Criteria  * Under-55 * Requires physical assistance to access the community * Unable to participate in exercise for medical reasons/contraindications\* ***see page 3*** * **Ongoing medical investigations** that preclude starting exercise immediately e.g., cardiac investigations * Unable to manage activities of daily living independently e.g., MDT management required * Wheelchair user * **Reliance on four wheeled walker or zimmer frame e.g., unable to achieve 30 seconds in unsupported stand** * Vestibular diagnosis with no other multifactorial or balance problems * Residents in care homes * Neurological condition – liaise with the falls prevention team directly **prior** to making a referral (livewell.fallstherapyteam@nhs.net) |
| I confirm to my knowledge that no exclusion criteria are present  \*If the criteria are not met/exclusions are present please complete the **appropriate referral** form to the correct service. | | |
| **Personal Information**  **Person’s name: NHS no: Date of birth:**  **Address *(include permanent address if temporary):***  **Tel:**  **Permission to contact NOK: Yes  No**  **NOK name and contact details:**    **GP name and surgery:** | | |
| **Referrers Details:** *(by completing this section you are confirming the person has consented to the referral)*  **Date of referral:**  **Referred by *(name, position, location):***  **Tel. no: Email:** | | |
| **Reason/s for Referral:** (*What does the individual want to improve/get back to?)* | | |
| **Triage Questions** *(the individual will be assessed by the most appropriate professional within the team e.g., physiotherapist or exercise specialist)*  **Is the individual experiencing any of the following?**   |  |  |  |  | | --- | --- | --- | --- | | Marked asymmetry |  | \*Unexplained falls |  | | Complex balance disorder, including unmanaged vestibular disturbance markedly impacting on everyday function |  | New pain |  | | A new diagnosis, *e.g., diabetes, angina that requires 1:1 monitoring of exercise* |  | Unmanaged visual disturbance |  | | A sudden deterioration of physical function |  | Breathlessness ++ |  | | None of these |  |  |  |   **\*If the person has experienced recurrent falls, unexplained falls, a long lie, or loss of consciousness (or suspected) please confirm that any possible medical causes of falls have been assessed/investigated *(we do not have access to medical support within the team)*: Yes  No**    **By whom: GP  Geriatrician  Advanced practitioner  Other** *Please state:*  **What was the outcome of the investigations/interventions?** *(e.g., lying/standing BP, cardiac assessment)*  Link to World Falls Guidelines: <https://www.bgs.org.uk/wfg> | | |
| **Relevant Medical History: \*For GP’s please attach GP summary** | | |
| **Medication: \*For GP’s please attach GP summary** | | |
| We aim to complete all assessments in Mount Gould Hospital Local Care Centre, or another community-based venue.  **Is there a clinical need for the individual to be seen at home? Yes  No** *(please state):*  **Are there any known lone worker risks to staff? Yes  No** *(please state):* | | |

\***Absolute Contraindications to Exercise (from exclusion criteria)**

* **Uncontrolled** angina
* Resting Systolic BP> 180 mmHg or resting Diastolic BP > 100 mmHg
* Tachycardia >100 bpm
* Significant, unmanaged postural hypotension
* Acute systemic illness (e.g., acute cancer-related problems, pneumonia)
  + **Unstable** or acute heart failure (including **recent** myocardial infarction or ECG changes, that have not yet been medically managed)
* Recent **injurious** fall **without** a medical examination