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| **Falls Prevention Team Referral Form (For Non-Physiotherapists)****Email your Referral to:** **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?**

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| 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