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| **Referral Form for FaME (Falls Management Exercise) Programme** |
| Email the completed referral form marked to: livewell.oyp@nhs.netPlease put ‘FaME Referral’ in the subjectIf you are wanting to refer to the Falls Prevention Physiotherapy Team please complete the Falls Prevention Referral form and use the email address on the form.  |
| **About FaME** |
| ***Confirm that the individual has read through the What is FaME? information Sheet or has been signposted to*** https://www.oneyouplymouth.co.uk/fame[ ]  |
|  **FaME Locations** |
| We offer FaME in locations across the city. Prior to completing the criteria checklist please confirm that the person can attend one of the venues listed on the website: https://www.oneyouplymouth.co.uk/fame |
|  **FaME Criteria Checklist**  |
| Age 55 or over and live in Plymouth, have a Plymouth GP, or live in the Plymouth City Council boundary. |[ ]
| The person has **one** or more of the following:* Fallen in the past 12 months (landed on the floor or lower level unintentionally)
* Sometimes feel concerned about their balance/stopping doing the things they enjoy
* Fearful of falling
 | [ ]  |
| **\***The person has experienced 3 falls or less in the last 12 months **or** has had a multifactorial falls assessment and falls risks have been managed. |[ ]
| The person has not experienced a fall resulting in a loss of consciousness or possible loss of consciousness in the last 12 months without appropriate investigation and intervention?  | [ ]  |
| The person has not experienced a recent injury fall without seeking a clinician review? E.g., bruises, cuts, sprains, strains, head injury | [ ]  |
| **\***The person has not experienced an injury-related fall resulting in a recent hospital admission (last 3 months) without a multifactorial falls assessment being completed? |[ ]
| **\***The person has not presented with any unexplained falls without appropriate investigation and intervention (e.g., falls due to dizziness, light headedness, palpitations, numbness, feeling unwell, new deterioration in walking etc.) |[ ]
| **Please provide any information regarding falls history, medical assessment, input or investigations that have been completed (essential if the person has presented with unexplained or falls resulting in loss of consciousness):** |  |
| **\***The person is not awaiting medical investigations, pending surgery, or treatment that would affect their ability to start a structured exercise programme e.g., cardiology investigations, falls clinic etc. |[ ]
| The person is not receiving new treatment following a fall or other recent illness e.g., physiotherapy, or ongoing medical treatment |[ ]
| The person does not have a progressive neurological condition e.g., stroke with marked weakness/other longstanding symptoms, Parkinson’s Disease, Multiple Sclerosis, Motor Neurone Disease etc. | [ ]  |
| They can independently leave their property on foot to socialise, go shopping, and attend appointments without needing the physical assistance from another |[ ]
| They understand simple instructions and know when they’ve had enough and need to rest |[ ]
| **\***They can stand up from a chair of knee height without needing physical assistance |[ ]
| **\***They can stand unsupported without holding on to anything for 2 minutes |[ ]
| They have not already attended FaME in the past 12 months  |[ ]
| The person is not experiencing unexplained chest pain or breathlessness  |[ ]
| The person is keen to give FaME a go! |[ ]
| **Does the person meet FaME criteria? (all boxes checked)***If the person does not meet some or all of the criteria marked with a* ***\**** *consider referring to the Falls Prevention physiotherapy team via the* ***Falls Prevention Team Referral Form.*** |[ ]
| **Please confirm that the person has provided consent to the Falls Prevention Team at Livewell Southwest to contact their GP surgery to obtain a patient summary (containing all their medical and medication history)** |[ ]
| **Personal and Referrers Information** |
| **Referrers Details****Name: Designation:****Email: Telephone:****Individual’s Details****Person’s Name: Date of Birth:** **Address:** **Tel:** **GP Surgery:****Permission to contact NOK if required?** [ ] **Next of Kin Relationship:** **Next of Kin Name: NOK Contact No:**  |