**FALLS SERVICE REFERRAL FORM**

**REFERRAL CRITERIA**

**PLEASE NOTE the patient must have fallen TWICE in the last year and one of these falls must have been in the last 6 months; be over 65 years; ambulant and medically well enough to be assessed and not currently an inpatient. If the patient has only fallen once, please consider referring to Single Point of Access for therapy or care needs 01865 903750**

**TELEPHONE OR EMAIL FOR ADVICE: 01865 903400 E-MAIL:** [**falls@oxfordhealth.nhs.uk**](mailto:falls@oxfordhealth.nhs.uk)

|  |  |
| --- | --- |
| **PATIENT NAME:**  **ADDRESS:**  **POSTCODE**:  **TELEPHONE NUMBER:** | **DOB:**    **NHS NUMBER:**    **HOSPITAL NUMBER (if known):**  **Is patient aware of referral: Y/N**  **Consent for us to access medical records: Y/N** |

|  |  |  |
| --- | --- | --- |
| GP name:  Practice address:  Postcode:  Is GP aware of referral: Y/N | | Other contact details:  Name:  Relationship:  Tel: |
| Other agencies/services involved: |
| **Fall in the last 6 months?** Yes/No **Number of falls in the last 12 months** 1 / 2 / 3 / 4+ | | |
| **Consequences of fall/s please tick:** Injury Bruising/laceration  Loss of confidence Required help to get up | | |
| **Are they taking any medications (taking 4 or more can increase the risk of falls)** Yes/No If yes please list:- | | |
| **RELEVANT MEDICAL HISTORY/MEASURES ALREADY TAKEN TO REDUCE FALLS RISK:** | | |
| **Referrers contact details:**  NAME:  Address:  Profession: | Tel:  Department:    Date of referral: | |