Western Health

WHCOR401

Falls Clinics Referral Form

(Incorporating Falls & Mobility Clinic and Falls & Fracture Clinic)

Email: Falls&FractureClinic@wh.org.au

Fax: 9923 6624

Patient Name: .....

Address: .....

Suburb: .....

Postcode: ..... Telephone: .....

DOB:_____/_____/_____Marital Status: .....

Medicare No:	**DVA No (if applicable):**
Country of Birth:	**Aboriginal or Torres Strait Islander** ☐ Yes ☐ No
Primary language:	**Interpreter** ☐ Yes ☐ No

GP Details: ☐ ***Western Health patients: GP details as per iPM/EMR***

GP Name: ..... **Provider Number:** .....

Clinic Name: .....

Address: ..... **Suburb:** .....

Postcode: ..... **Ph:** .....**Fax:** .....

Referrer Details:

Name: ..... Ph: ..... ☐**As per GP Details above**

DEXA Scan Required? ☐ Yes ☐ No

Required Criteria for referral to be accepted:

- ☐ **Aged 65 and over or Aboriginal & Torres Strait Islander aged 55 and over.**
- ☐ **Patient does not reside in a high-level care facility.**
- ☐ **History of Falls (please tick all that apply):**
  - ☐ Patient reports multiple falls in the last 12 months.
  - ☐ Patient reports ≥2 falls in the last 6 months.
  - ☐ Unexplained falls with apparent complex medical cause
  - ☐ Single faller with established gait and/or balance deficit

Additional referral information (Please tick all that apply)

- ☐ History of symptomatic or asymptomatic fragility fracture
- ☐ Clinical or paraclinical (e.g., Low BMD) risk of fractures

Other Specialist /Allied Health Involvement:

☐ Yes ☐ N/A	**Has the patient been referred to Cardiology Outpatient Clinic?** *If cardiological conditions such as syncope, arrhythmia or valvular heart disease are the primary causative factor for the falls.* If no, please refer: Cardiology (westernhealth.org.au)
☐ Yes ☐ N/A	**Has the patient been referred to Neurology Outpatient Clinic?** *If neurological condition/s such as seizure disorder, stroke, Parkinson's disease, or Multiple Sclerosis are the primary causative factor for the falls.* If no, please refer: Neurology, Neurophysiology and Stroke (westernhealth.org.au)
☐ Yes ☐ N/A	Patient has been reviewed by a geriatrician and underwent falls work-up in < 12 months or other specialists of relevance such as neurosurgeon, orthopedic surgeon, and pain specialist etc.

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☐ Yes ☐ No	Reviewed by Physiotherapy for falls management in last 6 months
☐ Yes ☐ No	Reviewed by Occupational therapy for falls management in the last 6 months
☐ Yes ☐ No	Occupational Therapy home assessment completed in last 6 months

Please forward any correspondence from Specialists

Falls frequency (if applicable)

Patient perceptions of the cause/s of the reported falls:
(e.g., dizziness, weakness, legs gave away, pain, balance, tripping, uneven ground)

Cognitive state: ☐ Normal ☐ Minor changes ☐ Confused ☐Dementia.

Recent cognitive screen score (if applicable): **Date:**

Mobility: ☐ Independent ☐ Assisted ☐ Unable

Decline in function/mobility in last 6 months ☐ Yes ☐ No

Please note: *To assist with the Clinic assessment, please attach the following:*

☐ Yes ☐ No	Current medication list attached
☐ Yes ☐ No	Current medical history attached
☐ Yes ☐ No ☐ N/A	Recent hospital discharge summaries (other than Western Health)
☐ Yes ☐ No ☐ N/A	Results of any investigations (including pathology) or other specialist reports

Consent:

Patient has consented to this referral and willing to attend:☐ Yes ☐ No

Patient has consented to be referred to allied health/Community program (if identified) ☐ Yes ☐ No