Tayside Falls Service - Clinician Referral

Name: Date of Birth/CHI: Address: AFFIX LABEL Post code:	Telephone: GP/Practice: Next of kin:

Level 1 Falls Screen	Yes	No	Don't Know
Has the person fallen more than once in the previous 12 months?			
Did they have any dizziness/blackouts/loss of consciousness at the time of the fall/s			
Do they have any difficulties with walking or balance?			
Are they struggling to carry out their usual daily activities following the fall/s			
Are they afraid of falling?			

FALLS HISTORY *(please give as much information as you can)*

Do they use a walking aid? YES/NO If yes what do they use?

MEDICAL HISTORY*(please give as much information as you can, eg. Diabetes, epilepsy, cardiac problems, confusion)*

N.B. Nursing home residents and those with advanced confusion / cognitive impairment should be discussed prior to referral.

CURRENT MEDICATION*(please give as much information as you can)*

CONSENT

The person is willing to have a further falls risk assessment if necessary. They understand this may involve a referral to other members of the health care team. They have consented that details from this assessment may be shared with other health care professionals.

Signed:…….. Date:……

Signing on behalf of the person indicates verbal consent has been obtained

REFERRER DETAILS

Name: Designation:
Base: Tel:
Consultant/Specialty:

Please email your completed referral form to your local Falls Service

Angus	**Dundee**	**Perth & Kinross**
Falls Service Co-ordinator Physiotherapy, Links Health Centre Frankwood Way Montrose, DD10 8TY Tel: 01356 665170 Email: Tay.angusfallsservice@nhs.scot	Falls Co-ordinator Royal Victoria Day Hospital Jedburgh Road, Dundee, DD2 1SP Tel: 01382 425665 / 423140 Email: Tay.dundeefallsreferral@nhs.scot	Assessment Clinic for the Elderly Perth Royal Infirmary Perth, PH1 1NX Tel: 01738 473482 Fax: 01738 473313 Email: Tay.pkelderlyassessment@nhs.scot

Fife: Email: Fife-UHB.icassreferralsfife@nhs.net