*\*\* CCC please note - This is to be processed to Osteoporosis Systm1 Unit\*\**

**Falls Prevention Co-ordinator Referral Form**

**All Fields Are Mandatory.** Incomplete forms will be returned.

|  |
| --- |
| **Patient Details** |
| Name:  | Address:  Postcode:  |
| D.O.B:  |
| NHS No:  | Telephone: |
| Does this person live alone: Yes [ ]  No [ ] Details: Is the person aware of the referral: Yes [ ]  No [ ]  | Next of kin details if appropriateName: Relationship: Tel / Mobile: Are they aware of the referral: Yes [ ]  No [ ] Alternative contact:  |
| Falls History: Reason for Referral: Falls Risk [ ]  Assessment [ ] Medical History:Medication: Fragility Fracture History:  |
| **Lying and Standing Blood Pressure** |
| Lying: Standing – 1 min:Standing - 3 mins: |
| **Assessments Completed** |  |
|  **(For ESNEFT Community Healthcare Teams only).** Has initial falls assessment been completed?Yes [ ]  No [ ]  | **(For all other Organisations.** eg Care homes, Social care, etc**)** Has the patient been reviewed by the:1. Community Healthcare TeamYes [ ]  No[ ]
2. GP Yes [ ]  No [ ]
 |
| **Other Services Involved** |
| Are there any other services involved with the care of this patient? E.g. District Nurse, Practice Nurses, Community Matron, Social worker, etc.Contact Details:  |
| Have you referred the person to any other service? If yes, list them and include date of referral. |
| **Other Useful Information** |
| I.e. home situation, family support, able to get up from the floor independently, mobility aids in situ, personal alarm. |
| **Referral Urgency (Please tick one box)** |
| GREEN - 1 week [ ]  GREEN – Non Urgent (over a week) [ ]  |
| Date of referral: Team/Department: | Referrers Name: Designation: Phone/Mobile: Email:  |

**Please return this form to the Care Co-ordination Centre.**

**Email:** suffolkcommunityhealthcare.referrals@nhs.net

**Post:** Care Co-ordination Centre, East Suffolk and North Essex NHS Foundation Trust, 86 Sandy Hill Lane, Ipswich, IP3 0NA

**Telephone:** 0300 123 2425