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| Longridge HospitalSt Wilfred’s TerraceLongridgePrestonPR3 3WQTel 01772 777999 or email MAP@lscft.nhs.uk or fax 01772 520520 |
| **Referral Criteria (please tick) *patient MUST satisfy all criteria*** |
| TITLE |     |
| FORENAME |  | SURNAME |  |
| DATE OF BIRTH  |  | NHS NUMBER |  |
| ADDRESSTOWNPOSTCODE |  | Contact Number |  |
| Can the person be contacted directly? |   | NEXT OF KIN(NOK)CONTACT DETIALS |  |
| GP |  | Practice Address Telephone number |  |
| **Referrer Details**  |
| Referrer Name |  | Designation |  |
| Contact Number |  | Base |  |
| Email address |  |
| Signature |  | Referral Date |  |
| **NB – if patient is wheelchair dependent, being hoisted and has no useful mobility, the referral will NOT be accepted. You may need to speak to GP to ask for community physiotherapy assessment** |
| **Please continue overleaf**  |
| Does the person live alone?  |   | Is the person housebound?  |   |
| Does the person have communication difficulties?  |    | If Yes, please give details |  |
| Is an interpreter/ signer required?  |  If interpreter needed, which language? |  |   |
| Are there any concerns about the person’s ability to understand information and engage in an assessment and possible rehabilitation programme? |     |
| Past Medical History | Other:-  |
| Medications/ recent changes |  |
| ***For PMH and Medications please attach any further information on a separate sheet if necessary.******Please attach any relevant discharge summaries, clinic letters, other correspondence or reports*** |
| **History of falls**Is the person having falls? |   | If yes how often? |  |
| Number of falls? | The last 4 weeks :-The last 3months:-The last 12months:- |
| Any pattern to the falls? I.e. Time of day, Mechanism, equipment involved? |  |
| Brief description of most recent fall | Date of fall:- Did they attend A&E:-Loss of consciousness:-Palpitations:-Light headedness or dizziness:- | Has the person been unwell recently? |   |
| Injuries | Fracture? where:-Head Injury:-Severe Laceration:-Any other injuries:- |  |  |
| Is there a history of any falls in the previous year? |   | Number of falls in the last year? |  |
| Is the person on more than 4 medications per day? |   | Does the person have a history of stroke or Parkinson’s Disease? |   |
| Does the person need to use their hands to stand up from a chair of knee height?(before injury) |   | Does the person report any problems with their balance? |    |
| Current level of mobility: | Walks independently:-With supervision/support:-Walks with aid:- | Current Level of transfers: | Independently:-With Support:- |
| Has there been a recent change in mobility and/or activities of daily living? |   | Why does the person think they are falling? |  |
| Have they done anything to reduce or prevent further falls? |  | Any other agencies involved/ referred to? Please give details |  |
| Has a Safeguarding Concern been identified |   | Comments if Yes |  |
| Double Up required? |   | Armed services veteran? |    |
| **For Care Staff only:**  | Staff agree to work with the Falls Prevention Service and Implement treatment plans as necessary  |

**PRE-REFERRAL CHECKLIST**

Please complete the checklist below. This information will be used in our assessment process and will enable you to take a pro active approach in managing falls.

|  |  |
| --- | --- |
| NAME: | DATE OF BIRTH: |
| **ARE THESE RISK FACTORS CONTRIBUTING TO THE PERSON’S FALLS?** | **YES** | **NO** | **ACTION** |
| Does the person use an appropriate walking aid? *Appropriate-correct height,prescribed to the person/person specific, in good condition, ferrules not worn, walking sticks not split.* *Walking aid- frame, stick, 3 or 4 wheeled walker* |  |  | **IF NO:** Consider referral to Community Physiotherapists for assessment via GP  |
| If the person has had previous fractures or has osteoporosis, are they taking calcium, vitamin D or bisphosphonates? |  |  | **IF NO:** Refer to GP for assessment |
| Is the person wearing appropriate footwear?*Appropriate – well fitted, non slip sole, supportive* |  |  | **IF NO:** Discuss changing footwear with resident.  |
| Does the person have any foot care needs?*Eg. Needs toenails cutting, has corns, callouses, bunions, hard skin, diabetic, odema* |  |  | **IF YES:** Refer to chiropodist |
| Has the person had an annual eye check? Is the person wearing appropriate glasses?*Appropriate- correct prescription, belonging to the person, issued bu refuses to wear, clean, needs prompting?* |  |  | **IF NO:** Arrange optician’s appointment for review |
| Has the person changed their glasses recently?*Eg. Stronger/bifocal/varifocal*  |  |  | **IF YES:** May need prompting/reassurance to adjust. May require review my optician if problem does not resolve. |
| Does the person have any eye conditions that require treatment?*Eg. Infection, Cataracts, Glaucoma/macular Degeneration, needs eye test or GP review* |  |  | **IF YES:** Refer to GP/Optician for assessment or review. |
| Are the falls alcohol-related?*Eg Excess alcohol, interaction between alcohol and medications* |  |  | **IF YES:** Discuss reducing alcohol intake with resident and/or family.  |
| Does the person show signs of being acutely unwell?*Eg. Additional confusion /temperature /Lost/gained excessive weight, dehydrated, constipated, UTI or other infection* |  |  | **IF YES:** Review by GP/Nurse. Urinalysis by appropriate member of staff.  |
| If the person takes more than 4 medications or culprit falls medications, have they had a medication review? |  |  | **IF NO:** Review by GP |
| If the person has any pain, is it being managed adequately? |  |  | **IF NO:** Review by GP/Nurse |
| Does the person experience dizziness? *Eg. When standing up, moving from lying to sitting, turning head* |  |  | **IF YES:** Review by GP/Nurse to check lying/standing blood pressure |
| Does the person have any continence problems that impact on their risk of falls?*Eg Frequency, urgency, night time, stress* |  |  | **IF YES:** Consider implementing toileting regimes. Commode/urinal for night time. Referral to Continence team.  |
| Have all environmental hazards been considered?  |  |  | **IF NO:** Refer to environmental checklists |
| Is all necessary equipment in place to help with transfers/ADLS? |  |  | **IF NO:** Consider equipment such as grabrails, toilet frames, raised toilet seats etc. Ensure furniture is at a suitable height. |
| Is the person falling when getting out of bed or out of a chair? Establish why the person is waking up and getting up/consider increased surveillance, night time checks/putting bed to lowest height setting or purchase of a very low bed |  |  | **IF NO:** Consider bed / chair occupancy sensors – see list |

Complete in full the falls history for the past 3 months.

Please also summarise the last 12 months falls including location, time and if the falls were witnessed/ unwitnessed and if the client injured themselves.

Note section one is an example

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| **No.** | **Date** | **Time** | **Location** | **What was the person doing at time of fall?** | **Able to get up?** | **Injuries** | **Likely cause of fall** | **Preventative actions taken after fall** |
| **1** | **13.03.2016** | **02.15** | **Hall**  | **Unwitnessed fall – patient found on her side.****Not using walking frame**  | **No had help from 2 staff** | **Skin laceration to left forearm**  | **Unknown**  | **Observations at night increased. Urinalysis completed****Consideration of sensors**  |
| **2** |  |  |  |  |  |  |  |  |
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| **10** |  |  |  |  |  |  |  |  |