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| Longridge Hospital  St Wilfred’s Terrace  Longridge  Preston  PR3 3WQ  Tel 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 |  |
| ADDRESS  TOWN  POSTCODE | |  | 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** |  |  |  |  |  |  |  |  |
| **3** |  |  |  |  |  |  |  |  |
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| **9** |  |  |  |  |  |  |  |  |
| **10** |  |  |  |  |  |  |  |  |