



(Affix client label here)

URN:

Family Name:

Given Names:

Date of Birth:

Sex: M F

Falls Management & Prevention Program Referral Checklist
Referral Guide to Members of the Multi-Disciplinary Team

Please check if your client would benefit from referral to other members of the mutli-disciplinary team.
This checklist can be completed by a health professional from any discipline

REFERRAL CHECKLIST		If YES to ANY question consider referral to:	Urgent	Semi-urgent	Non-urgent	In place now
Assessed By:	Organisation:					
Discipline:	Date:	Ph:				
Physical Status	<input type="checkbox"/> Did the client lose consciousness at the time of the fall? Does the client have – <ul style="list-style-type: none"> <input type="checkbox"/> An acute illness <input type="checkbox"/> Postural hypotension/ dizziness <input type="checkbox"/> Blurred vision or other problems with their eyesight <input type="checkbox"/> Disorientation/confusion, impaired judgement or depression <input type="checkbox"/> A past history of fracture & no osteoporosis investigations 	<input type="checkbox"/> GP/Medical Name:..... Practice: Date actioned:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medications	Does the client - <ul style="list-style-type: none"> <input type="checkbox"/> Take 4 or more medications &/OR <input type="checkbox"/> Take medications that affect both CV and CNS 	<input type="checkbox"/> GP/Medical <input type="checkbox"/> Pharmacist for Home Medication Review Name:..... Date actioned:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mobility & Balance	Does the client appear or report - <ul style="list-style-type: none"> <input type="checkbox"/> Difficulty standing unsupported for 10 seconds, first with eyes open then with eyes closed <input type="checkbox"/> Feeling unsteady when walking, turning or performing day to day activities 	<input type="checkbox"/> Physiotherapist Organisation: Date actioned:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Activities of Daily Living & Home Environment	Does the client appear or report - <ul style="list-style-type: none"> <input type="checkbox"/> Feeling unsafe or having difficulties with activities of daily living: eg showering, toileting, getting in & out of bed, dressing or domestic duties? <input type="checkbox"/> Feel that assessment of the home environment would make them feel safer/less anxious eg equipment for bathroom safety? 	<input type="checkbox"/> Occupational Therapist Organisation: Date actioned:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Support Services	Does the client - <ul style="list-style-type: none"> <input type="checkbox"/> Require assistance to cope with carer responsibilities or decreased independence as a result of a fall or: eg linkage with support services such as Meals on Wheels or home help 	<input type="checkbox"/> Community Nurse Organisation: Date actioned:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Page one Abridged Version

Forward a copy of this Checklist with your referral/s to other service provider/s and the client's preferred GP.



BINDING MARGIN – Do Not Write Here





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Referral Guide to Members of the Multi-Disciplinary Team

REFERRAL CHECKLIST

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Organisation:

Discipline:

Date:

Ph:

**If YES to ANY question
consider referral to:**

Urgent

Semi-urgent

Non-urgent

In place now

Feet & Footwear	Does the client - <input type="checkbox"/> Have foot pain or foot deformities affecting mobility <input type="checkbox"/> Wear ill fitting foot wear when mobilising	<input type="checkbox"/> Podiatrist <i>Organisation:</i> <i>Date actioned:</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Continence	Does the client - <input type="checkbox"/> Experience any difficulties toileting or have urge incontinence	<input type="checkbox"/> Continence Adviser <i>Organisation:</i> <i>Date actioned:</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nutritional Status	Is the client - <input type="checkbox"/> Underweight and/or frail <input type="checkbox"/> Losing weight unintentionally	<input type="checkbox"/> Dietitian <input type="checkbox"/> <input type="checkbox"/> Medical <i>Organisation:</i> <i>Date actioned:</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Social Support	Would the client benefit from: <input type="checkbox"/> Counselling or support to assist with issues associated with the fall: eg alcohol consumption, isolation or depression	<input type="checkbox"/> Social Worker <input type="checkbox"/> Psychologist <i>Organisation:</i> <i>Date actioned:</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety	Does the client - <input type="checkbox"/> Have a fear of falling that is significantly limiting their lifestyle?	<input type="checkbox"/> Psychologist <i>Organisation:</i> <i>Date actioned:</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

COMMENTS:

Page one and two comprises the full version

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