Queensland Government

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

(Affix client label here)

URN:

Family Name:

Given Names:

Date of Birth: Sex: ☐ M ☐ F

*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<br>*Assessed By:* *Organisation:*<br>*Discipline:* *Date:* *Ph:* | | **If YES to ANY question consider referral to:** | **Urgent** | **Semi-urgent** | **Non-urgent** | **In place now** |
|---|---|---|---|---|---|---|
| Physical Status | ❑ **Did the client lose consciousness at the time of the fall?**<br>Does the client have –<br>❑ An acute illness<br>❑ Postural hypotension/ dizziness<br>❑ Blurred vision or other problems with their eyesight<br>❑ Disorientation/confusion, impaired judgement or depression<br>❑ A past history of fracture & no osteoporosis investigations | ❑ **GP/Medical**<br>*Name:……*<br>*Practice:*<br>*……*<br>*Date actioned:*<br>*……* | ❑ | ❑ | ❑ | ❑ |
| Medications | Does the client -<br>❑ Take 4 or more medications<br>&/OR<br>❑ Take medications that affect both CV and CNS | ❑ **GP/Medical**<br>❑ ***Pharmacist for Home Medication Review***<br>*Name:……*<br>*Date actioned:*<br>*……* | ❑<br>❑ | ❑<br>❑ | ❑<br>❑ | ❑<br>❑ |
| Mobility & Balance | Does the client appear or report -<br>❑ Difficulty standing unsupported for 10 seconds, first with eyes open then with eyes closed<br>❑ Feeling unsteady when walking, turning or performing day to day activities | ❑ **Physiotherapist**<br>*Organisation:*<br>*……*<br>*Date actioned:*<br>*……* | ❑ | ❑ | ❑ | ❑ |
| Activities of Daily Living & Home Environment | Does the client appear or report -<br>❑ Feeling unsafe or having difficulties with activities of daily living: eg showering, toileting, getting in & out of bed, dressing or domestic duties?<br>❑ Feel that assessment of the home environment would make them feel safer/less anxious eg equipment for bathroom safety? | ❑ **Occupational Therapist**<br>*Organisation:*<br>*……*<br>*Date actioned:*<br>*……* | ❑ | ❑ | ❑ | ❑ |
| Support Services | Does the client -<br>❑ 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 | ❑ **Community Nurse**<br>*Organisation:*<br>*……*<br>*Date actioned:*<br>*……* | ❑ | ❑ | ❑ | ❑ |

**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.*

*Created by BSCHSI a collaboration between Brisbane Inner South Division of GP's, Mater Health Services( DAART) and Brisbane South Community Health Services*

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FALLS MANAGEMENT AND PREVENTION CHECKLIST

QEEC0001302.1 06/05

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URN:

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| REFERRAL CHECKLIST | | | If YES to ANY question consider referral to: | Urgent | Semi-urgent | Non-urgent | In place now |
|---|---|---|---|---|---|---|---|
| *Assessed By:* | *Organisation:* | | | | | | |
| *Discipline:* | *Date:* | *Ph:* | | | | | |
| Feet & Footwear | Does the client -<br>❑ Have foot pain or foot deformities affecting mobility<br>❑ Wear ill fitting foot wear when mobilising | | ❑ **Podiatrist**<br>*Organisation:*<br>……<br>*Date actioned:*<br>…… | ❑ | ❑ | ❑ | ❑ |
| Continence | Does the client -<br>❑ Experience any difficulties toileting or have urge incontinence | | ❑ **Continence Adviser**<br>*Organisation:*<br>……<br>*Date actioned:*<br>…… | ❑ | ❑ | ❑ | ❑ |
| Nutritional Status | Is the client -<br>❑ Underweight and/or frail<br>❑ Losing weight unintentionally | | ❑ **Dietitian**<br>❑ **Medical**<br>*Organisation:*<br>……<br>Date actioned:<br>…… | ❑ | ❑ | ❑ | ❑ |
| Social Support | Would the client benefit from:<br>❑ Counselling or support to assist with issues associated with the fall: eg alcohol consumption, isolation or depression | | ❑ **Social Worker**<br>❑ **Psychologist**<br>*Organisation:*<br>……<br>*Date actioned:*<br>…… | ❑<br>❑ | ❑<br>❑ | ❑<br>❑ | ❑<br>❑ |
| Anxiety | Does the client –<br>❑ Have a fear of falling that is significantly limiting their lifestyle? | | ❑ **Psychologist**<br>*Organisation:*<br>……<br>*Date actioned:*<br>…… | ❑ | ❑ | ❑ | ❑ |

**COMMENTS:**

**Page one and two comprises the full version**

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