**Hull and East Riding Integrated Falls Service**

**Referral Form**

**\*Please Note: Incomplete forms will be returned, resulting on delayed assessment\***

|  |  |
| --- | --- |
| Name of Referrer:  | Date of Referral:  |
| Job Title:  |
| Address & contact number/email of referrer:  |
| **PATIENT DETAILS** |
| Registered GP:  | GP Practice Address:  |
| Title:  | Forename:  | Surname:  | Known as:  |
| Date of Birth:  | NHS Number:  |
| Gender: | Ethnicity: |
| Religion: |
| Address:  |
| Patient home number:  | Patient mobile number: |
| Preferred contact number: Home [ ]  Mobile [ ]   | Email address: |
| Lives alone/carers/nursing home/residential home: | Next of Kin/Carer/Emergency contact: |
| Consent to contact via SMS  | Yes [ ]  | No [ ]  |
| Consent to contact via SMS & Email  | Yes [ ]  | No [ ]  |
| Consent to share medical information:  | Yes [ ]  | No [ ]  |
| Translator required: | Yes [ ]   | No [ ]  | Language required\*: |
| Chaperone required: | Yes [ ]   | No [ ]  |
| Accessible information needs:  | Yes [ ]   | No [ ]   | Detail needs: |
| Diagnosis:  | Client aware of diagnosis?  | Yes [ ]  | No [ ]  |
| Are there any other services involved in patient’s care | Yes [ ]   |  No [ ]  | Don’t know [ ]  |
| **SUPPORTING INFORMATION** |
| Is there a Lone working risk?  | Yes [ ]  | No [ ]  |
| Is there a Safeguarding risk?  | Yes [ ]  | No [ ]  |
| Has the patient given consent for the referral?  | Yes [ ]  | No [ ]  |
| Any concerns re Mental Capacity?  | Yes [ ]  | No [ ]  |
| **ReSPECT** document in place?  | Yes [ ]   |  No [ ]  | **(If yes give details)** |
| Smoking: | Yes [ ]   |  No [ ]  | Don’t know [ ]  |
| **MEDICAL HISTORY** |
|  |
| **SOCIAL INFORMATION** |
|  |
| **MOST RECENT FALL** |
| Circumstances: Where? Why? What was the patient doing at time of their fall? When? |
| How many falls in the last 6 months and circumstances around these falls? |
| Any associated injuries:  | Bruises | Yes [ ]   |  No [ ]  | Broken bones | Yes [ ]   |  No [ ]  |
| History of Collapse, Loss of consciousness or blackouts? | Yes [ ]   |  No [ ]  | **(If yes give details)** |
| **Reason for referral: (The reason for referral needs to be *clearly detailed*. Insufficient information will result in the referral being returned):** |
| **REFERRER, PLEASE INDICATE ADVICE GIVEN TO MINIMISE FALLS RISKS: FOR EXAMPLE** |
| Optician Ref made | Yes [ ]   |  No [ ]  | Advice against inappropriate footwear | Yes [ ]   |  No [ ]  |
| Referred for Lifeline | Yes [ ]   |  No [ ]  | Removed loose rugs/carpets | Yes [ ]   |  No [ ]  |
| Referred for Medication review | Yes [ ]   |  No [ ]  | Other – explain: |

**To make a referral please send via email to:** **chcp.247111@nhs.net** **or contact Tel – 01482 247111**

\* **Please note it is CHCP Policy that a family member or friend cannot be used for translation purposes\***