**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**](mailto: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\***