The Pennine Acute Hospitals NHS

TROH Falls Service Referral

Unit number _____

Surname _____

First Name _____

Address _____

_____

Postcode _____

Date of birth _____

Referral date _____

Referred by:

Name (print) _____

Position _____

GP _____

_____

Falls History

History of:	**Yes**	**No**
• Recurrent falls (2 or more in the last 12 months)?	O	O
• A single fall with an evident gait or balance problem ?	O	O
• An unexplained fall with multiple medical co-morbidities?	O	O
• Treatment with more than 4 drugs?	O	O

Ensure they are suitable for the Falls Clinic:

- No serious memory problem O
- Able to mobilise with a frame or stick(s) O
- Willing to attend O

Refer if patient meets all three criteria

Brief description of fall(s)

Past medical history

Medication list

Any additional information (interpreter required etc.)?

Blood pressure and pulse:

Lying

Standing

Results

Na	Hb	ECG:	please fax
K	WCC		
Urea	Plat	CXR:	please tick if done O
Creat			

Please tick to indicate the following have been sent:	Bone profile	O
	B12/ folate/ TFT	O

Signature:

Fax referral form to Dr. Raj Parikh's secretary on 0161 627 8694