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| cid:image003.png@01D6082D.C3917A50 |  | | Nottingham Heathcare NHS Trust is the largest mental health treatment provider in Europe operating at over 100 sites, employing over 6,500 people. | |
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|  | | **Specialist Falls Service Referrals** | | |
| The Specialist Falls Service provides **non-urgent** assessment for complex patients at risk of recurrent falls, who are registered with a BNSSG GP and who have already been screened for any acute medical problems.  Patients are seen at home or in our Sirona Specialist Falls Service Clinic. **This is Nurse / Therapist-led without a Consultant and there is no medical input.** | | |
| Date of Referral: | | Has the patient consented to this Referral? Yes 🞏 No 🞏 |
| Service you are referring into:  Does the patient have suspected syncope, blackout or unexplained fall?  Is the patient already on a community caseload    Are you asking for routine falls risk assessment with Physiotherapy and OT or multidisciplinary team  Referral to Specialist Falls Service | | 🞏 No 🞏 **Yes - please refer to Care of the Elderly Physician rather than the Specialist Falls Service**  🞏 No 🞏 **Yes - please consider asking the Community Team currently involved to complete a falls risk assessment template**  🞏 No 🞏 **Yes - please** **refer to Community Therapy or Physiotherapy outpatients; or Community Nursing if there is a nursing need**  🞏 No 🞏 Yes |

Patient Information:

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| --- | --- |
| Patient’s Name:  Address:  Postcode:  Contact Telephone Number:  First Language: | NHS Number:  Date of Birth:  Next of Kin’s Name:  Relationship to Patient:  NoK’s Contact Details/Access: |
| Patient’s current location/address  (If different from home address): | Communication or Cultural needs:  Interpreter 🞏 No 🞏 Yes |

Referrer / Patient’s GP Information:

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| --- | --- |
| Referrer’s Information: | Patient’s GP (if Referrer not GP/GP Practice): |
| Referrer’s Name:  GP Practice if applicable:  Address:  Postcode:  Contact Telephone Number:  Profession: | GP Name:  GP Practice:  GP Telephone Number:  Consultant (if applicable): |

Referral Details:

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| Has the patient already had a falls risk assessment in the last year? | **Yes / No** | |
| - **if yes** What was the outcome? | | |
| Please confirm that the patient has had a Falls blood screen (Thyroid, Vit B12 and folate, liver function, bone profile, kidney, full blood count) since this episode of falls started **Yes / No** | | |
| Risks: | | Referrals made to other agencies and other agencies involved: |
| Please provide   * the reason for referral * the patient’s / your expectations following the assessment;   any other relevant information: | | |
| Please provide past medical history, allergies and medications: | | |
| Please send referral via email to [Sirona.specialistfallsservice@nhs.net](mailto:Sirona.specialistfallsservice@nhs.net) | | |