

# Falls Prevention Patient Referral Form

|  |      |      |              |
|--|------|------|--------------|
| Patient:   |      |      | Referred to: |
| Gender: M / F  | NHI: | DOB: |              |
| Ethnicity: <input type="checkbox"/> NZ European<br><input type="checkbox"/> Māori<br><input type="checkbox"/> Pacific Island<br><input type="checkbox"/> Asian<br>Other: |      |      | Address:     |
| Patient's Address:   |      |      |              |
| Patient's phone:   |      |      | Phone:       |
| Patient's email:   |      |      |              |
| Diagnosis:   |      |      |              |

## Type of Referral

Type of specialist:

Exercise or falls prevention programme:

## Reason for Referral

### Physical activity

Balance difficulties  Lower body weakness

Gait or mobility problems  Foot abnormalities

### Underlying conditions

Medication review & consultation  Suspected neurological condition (e.g. Parkinson's disease, dementia)

Postural hypotension  Vision <6/12 in  R  L  Both

### Home Safety

Inadequate or improper footwear  Contenance or urgency problem

Home safety assessment and modifications

Other reason:

Other relevant information:

Referrer details: Date: