HUMBER RIVER HOSPITAL

Patient Identification

Falls Prevention Program Referral

Patient's Name: _____ Date of Birth: __mm/dd/yy__ Sex: F □ M □

Address: _____ Home Phone #: _____

Caregiver Name/Info: _____ Phone #: _____

OHIP #: _____ Ver. Code: _____ Languages: _____ Interpreter: □ Yes

Medical Information

Current Primary Diagnosis: _____

Medical History:

□ Hypertension	□ Stroke: (type)_____	□ History of Falls
□ Pacemaker	□ Seizures	□ Osteoporosis
□ Vascular Disease	□ Diabetes: (type)_____	□ Fractures: _____
□ Cardiac:_____	□ Cancer: (type) _____	□ Arthritis: _____
□ Dizziness/Syncope	□ Prescribed > 4 medications	□ Poor vision

□ Prescribed ≥ 1 high risk medication for falls (e.g. Benzodiazepines, opioids, psychotropics, anticholinergics, diuretics)

□ Other:_____

Reason for Referral

□ Recent Falls □ Fear of falling
□ Decreased mobility □ Poor balance □ Leg weakness

□ Other issues: _____

Interprofessional Assessment Includes:

- Consult/Assessment with a Geriatrician and Nurse
- Physiotherapy Assessment for ability to participate in a group exercise program
- Occupational Therapy assessment if appropriate

Referring Physician Name: _____ Signature: _____

Referring Physician Tel#: _____ Fax#: _____

Billing #_____ Date: _____

***** Screening Criteria on page 2 must be completed*****

Tel# 416-242-1000 ext. 21800 Fax# 416-242-1058 1235 Wilson Ave., Toronto, ON M3M 0B2

10070000044

Screening Questions

Question		Scoring	Indicators for Admission
1. Falls History:	a. Does the patient have a fear of falling?	Yes No	One or more Yes responses
	b. Has the patient had any falls in the last year? If yes, how many?	Yes No #____	
	c. Are there any tasks or activities that the patient has stopped doing because of their fear of falling?	Yes No	
2. Mobility	a. Does the patient have trouble walking or with balance?	Yes No	Need yes if responded No to 1a and 1b.
	b. Is the patient able to walk at least 3m (10ft)?	Yes No	Yes response is mandatory
	c. To walk the 3m, does the patient require assistance from another person?	Yes No	
3. ADLs	a. Does the patient require assistance with day-to-day tasks such as bathing, showering, preparing meals or other personal care?	Yes No	*A caregiver must be able to attend if patient requires assistance with toileting.
4. Cognition	a. Does the patient have difficulty with memory or does family state problems with memory?	Yes No	
	b. Is the patient able to follow 2-3 step commands?	Yes No	Yes response is mandatory
	c. Is the patient able to concentrate or focus in a group setting?	Yes No	Yes response is mandatory
	d. Can the patient follow instructions in simple English?	Yes No	

**** Is the patient interested in participating in the falls prevention program? ****

Exclusion Criteria

- Medical or psychiatric instability
- Moderate-severe cognitive impairment
- Complex needs with ADLs
- Poor endurance-unable to tolerate a 1-1$^{1/2}$ hour group exercise class

Tel# 416-242-1000 ext. 21800 Fax# 416-242-1058 1235 Wilson Ave., Toronto, ON M3M 0B2