WHCOR401

Booklet

Western Health

Falls and Fracture Clinic

Referral Form

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Please fax referral to (03) 8395 8262

Hospital UR#.....

Name: .....

Address: .....

Suburb: .....

Postcode: ..... Telephone: .....

DOB:_____/_____/_____Marital Status:

Referrers Name: ..... Position: ..... Tel/Page .....

Referring Hospital / Agency / Clinic: ..... Unit: ..... Ward:.....

Referred from: ☐ Hospital ☐ Sub Acute/Rehab/GEM ☐ Community ☐ Emergency ☐ Specialist ☐ GP

Hospital Admission Date: / / **Hospital Discharge Date:** / / ☐ not applicable

Contact Person/Next of Kin: ..... **Tel:** .....

Address: ..... Work: .....

Relationship: ..... Mobile: .....

Factors impacting on ability to attend a clinic appointment (transport etc): .....

Primary Carer: ☐ Yes ☐ No

Main diagnosis: .....

.....

.....

.....

Other health issues/past medical history.....

.....

.....

.....

Any infectious diseases: .....

Any allergies? .....

Current medications .....

.....

.....

(or attach list if available in another format)

Falls in past 6/12 months .....

.....

..... Is the patient at risk of presenting to hospital? ☐ Yes ☐ No

Cognitive State:

☐ Normal ☐ Minor Changes ☐ Confusion ☐ Dementia

Mobility:

☐ Independent ☐ Assisted ☐ Unable

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COMPLETE BELOW FOR REFERRALS FROM OUTSIDE WESTERN HEALTH

GP Name: ..... **Provider Number:** .....

Clinic Name: .....

Address: ..... **Suburb:** .....

Postcode: ..... **Ph:** ..... **Fax:** .....

Is GP aware of Referral ☐ Yes ☐ No **Has the patient consented to this Referral:** ☐ Yes ☐ No

Carer Availability	**Carer Relationship**	**Living Arrangements**	**Accommodation**
☐ No Carer	☐ Spouse/Partner	☐ Lives Alone	☐ Private (own/rent/purchase)
☐ Co-resident Carer	☐ Parent	☐ Lives with Family	☐ Outreach
☐ Non Resident Carer	☐ Child/Child in law	☐ Lives with Others	☐ Supported Community
	☐ Other Relative	☐ Not stated	☐ Residential Aged Care
	☐ Friend/Neighbour		☐ Residential Care Facility (not aged)
	☐ Foster Carer		☐ Other Accommodation

Country of Birth: Aboriginal or Torres Strait Islander ☐ Yes ☐ No

Medicare No: DVA No (if applicable):

Required Criteria (must tick all)

- ☐ Aged 65 and over
- ☐ No serious memory deficits
- ☐ Able to mobilise with frame or stick(s)
- ☐ Patient consent/willing to attend

Presentations (please tick all which apply)

- ☐ Multiple faller (>2 within last 12 months)
- ☐ Single faller with established gait and/or balance deficit
- ☐ Fall due to loss of consciousness
- ☐ Unexplained fall with apparent complex medical cause
- ☐ History of symptomatic or asymptomatic fragility fracture
- ☐ Clinical or paraclinical (BMD) risk of fractures

DXA Scan Required? ☐ Yes ☐ No

Note to GPs: *To assist with the Falls and Fractures Clinic assessment, we request that you kindly attach details including the patient history, relevant pathology results, list of medications and other relevant information such as existing care plans.*

Client Agreement: I ..... (client name) agree:

- To participate in the Falls and Fracture Clinic program
- That **information about my medical condition and care needs** can be supplied to the staff of these programs and the services providing assistance to me, including my local doctor,
- That the staff may **feed back to the hospital staff** about my recovery and the care needed

SIGNED: ..... (client) DATE: .....

CARER / GUARDIAN CONSENT

If the client is unable to give informed consent the guardian or a carer may sign on his/her behalf.

SIGNED: ..... (carer) DATE: ..... RELATIONSHIP: .....