



Falls Clinics Referral Form

(Incorporating Falls & Mobility Clinic and Falls & Fracture Clinic)

Email: Falls&FractureClinic@wh.org.au

Fax: 9923 6624

Patient Name:
 Address:
 Suburb:
 Postcode: Telephone:
 DOB: ____/____/____ Marital Status:

Medicare No:		DVA No (if applicable):	
Country of Birth:		Aboriginal or Torres Strait Islander ☐ Yes ☐ No	
Primary language:		Interpreter ☐ Yes ☐ No	
GP Details: ☐ <i>Western Health patients: GP details as per iPM/EMR</i> GP Name: Provider Number: Clinic Name: Address: Suburb: Postcode: Ph: Fax: Referrer Details: Name: Ph: ☐ As per GP Details above			
DEXA Scan Required? ☐ Yes ☐ No			
Required Criteria for referral to be accepted: ☐ Aged 65 and over or Aboriginal & Torres Strait Islander aged 55 and over. ☐ Patient does not reside in a high-level care facility. ☐ History of Falls (please tick all that apply): ☐ Patient reports multiple falls in the last 12 months. ☐ Patient reports ≥2 falls in the last 6 months. ☐ Unexplained falls with apparent complex medical cause ☐ Single faller with established gait and/or balance deficit Additional referral information (Please tick all that apply) ☐ History of symptomatic or asymptomatic fragility fracture ☐ Clinical or paraclinical (e.g., Low BMD) risk of fractures			
Other Specialist /Allied Health Involvement:			
☐ Yes ☐ N/A		Has the patient been referred to Cardiology Outpatient Clinic? <i>If cardiological conditions such as syncope, arrhythmia or valvular heart disease are the primary causative factor for the falls.</i> If no, please refer: Cardiology (westernhealth.org.au)	
☐ Yes ☐ N/A		Has the patient been referred to Neurology Outpatient Clinic? <i>If neurological condition/s such as seizure disorder, stroke, Parkinson's disease, or Multiple Sclerosis are the primary causative factor for the falls.</i> If no, please refer: Neurology, Neurophysiology and Stroke (westernhealth.org.au)	
☐ Yes ☐ N/A		Patient has been reviewed by a geriatrician and underwent falls work-up in < 12 months or other specialists of relevance such as neurosurgeon, orthopedic surgeon, and pain specialist etc.	



Falls Clinics Referral Form

(Incorporating Falls & Mobility Clinic and Falls & Fracture Clinic)

Email: Falls&FractureClinic@wh.org.au

Fax: 9923 6624

Patient Name:
 Address:
 Suburb:
 Postcode: Telephone:
 DOB: ____/____/____ Marital Status:

☐ Yes ☐ No	Reviewed by Physiotherapy for falls management in last 6 months
☐ Yes ☐ No	Reviewed by Occupational therapy for falls management in the last 6 months
☐ Yes ☐ No	Occupational Therapy home assessment completed in last 6 months
Please forward any correspondence from Specialists	
Falls frequency (if applicable)	
Patient perceptions of the cause/s of the reported falls: <i>(e.g., dizziness, weakness, legs gave away, pain, balance, tripping, uneven ground)</i>	
Cognitive state: ☐ Normal ☐ Minor changes ☐ Confused ☐ Dementia. Recent cognitive screen score (if applicable): Date:	
Mobility: ☐ Independent ☐ Assisted ☐ Unable Decline in function/mobility in last 6 months ☐ Yes ☐ No	
Please note: To assist with the Clinic assessment, please attach the following:	
☐ Yes ☐ No	Current medication list attached
☐ Yes ☐ No	Current medical history attached
☐ Yes ☐ No ☐ N/A	Recent hospital discharge summaries (other than Western Health)
☐ Yes ☐ No ☐ N/A	Results of any investigations (including pathology) or other specialist reports
Consent: Patient has consented to this referral and willing to attend: ☐ Yes ☐ No Patient has consented to be referred to allied health/Community program (if identified) ☐ Yes ☐ No	