East London NHS
NHS Foundation Trust

FALLS AND CHRONIC CONDITIONS SERVICE

REFERRAL FORM

Day Hospital
East Ham Care Centre
Shrewsbury Road
E7 8QP
Tel: 020 8475 2006 /2007
Team email: thedayhospital@nhs.net

REFERRAL DATE: _____

PATIENT DETAILS	**NHS No.**	**Date of Birth:**
Name:	**Address:** Post Code:	**Telephone:** **Sex:** ☐M ☐F **Ethnicity:**
General Practitioner (GP): Name: Address: Telephone:	**Significant Other (Next of Kin)** Name: Relationship: Telephone:	**First Language:** Interpreter Required: ☐Y ☐N **Religion:**

Referrer:	**Designation:**
Address:	Telephone:

REASON FOR REFERRAL	*Please provide/forward GP medical summary/additional medical information*

IF REFFERED DUE TO FALLS, please provide information as required

Symptoms at time of fall

Blackout	☐Yes	☐No	Paresis	☐Yes	☐No	Painful knees	☐ Yes	☐No
Chest pain	☐Yes	☐No	Palpitations	☐Yes	☐No	Lightheaded	☐Yes	☐No
Dizziness	☐Yes	☐No				Speech/ Visual disturbances	☐Yes	☐No

History of last fall

Injuries sustained

Witness account (if any)

Primary Diagnosis

CURRENT MEDICATION

MOVING AND HANDLING ASSESSMENT

Patient Characteristics

- Motivated ☐ Yes ☐ No
- Ability to assist ☐ Fully ☐ Partial ☐ Dependent
- Ability to comprehend instruction ☐ Good ☐ Moderate ☐ Poor

Weight: _____ Height: _____ Posture: _____

Weight bearing capability ☐ Fully ☐ Partial ☐ Unable
Upper limb strength ☐ Good ☐ Moderate ☐ Poor
Lower limb strength ☐ Good ☐ Moderate ☐ Poor

Equipment needed to transfer: hoist, other _____

Mobility: ☐ Mobile with aid of stick ☐ Rollator ☐ Zimmer Frame
☐ Gutter Frame ☐ Wheelchair User ☐ Independent

Has informed consent to treatment been obtained? ☐ Yes ☐ No

Able to answer the front door? ☐ Yes ☐ No

ALERT: Additional Information / Risk Factors:

ELIGIBILITY CRITERIA

- ✓ Must be over 50 years of age
- ✓ Living in Newham
- ✓ Must require the input of two or more members of the Multidisciplinary Team (MDT)