HERTFORDSHIRE FALLS LIAISON SERVICE REFERRAL FORM

PATIENT DETAILS	DETAILS OF PERSON REFERRING PATIENT
Name: Sex: Date of Birth: NHS No Address: Telephone number:	GP Name: Address: Telephone number**:**
Name of next of kin: Relationship: Address: Telephone number:	Referred by *(if different from above):* Occupation: Service name and address: Telephone number:
Date of Referral:	Is Patient aware of referral: Yes ☐ / No ☐

MOBILITY (Please tick✓ appropriate box)		
Is the patient ambulant unaided?	**Yes** ☐ **/ No** ☐	
Is the patient ambulant with walking aid?	**Yes** ☐ **/ No** ☐	
Is the patient wheelchair bound?	**Yes** ☐ **/ No** ☐	If yes, please refer to Hertfordshire Community Integrated services
Does the patient 1:1 intervention?	**Yes** ☐ **/ No** ☐	If yes, please refer to Hertfordshire Community Integrated services

MEDICAL HISTORY (Please tick✓ appropriate box)
Referral letter including medical history attached **Yes** ☐ **/ No** ☐
Do any of the patient's medical conditions exclude them from physical activity? **Yes** ☐ **/ No** ☐ Comment:

MEDICATION – Please attach prescription		
Has the patient had a change in medication recently?	**Yes** ☐ **/ No** ☐	Date:
Has the patient had a recent medication review?	**Yes** ☐ **/ No** ☐	Date:

OTHER SERVICES REFERRED TO (Please tick✓ appropriate box)			
See and Solve EAST (Integrated Point of Access)	☐	See and Solve WEST (Integrated Point of Access)	☐
Herts Home Safety Service	☐	Home First	☐
Other	☐		☐

Please send form to the Falls Liaison Service via secure NHS.NET Email: Falls.liaisonservice@NHS.NET
For any queries please contact **0800 007 5200** to speak to a member of the Falls team.