Milton Keynes Falls Prevention Service **Single Point of Access** Referral Form

MKCB FPS
Milton Keynes Community Based Falls Prevention Service

OFFICE USE ONLY
SPA RECEIVED ON: **DATE:**

BY: EMAIL: ☐ FAX: ☐ POST: ☐ PHONE: ☐ HAND: ☐

Please complete both sides of this form.

A fall is defined as *"an event whereby an individual comes to rest on the ground or another lower level with or without loss of consciousness"* (National Institute of Clinical Excellence 2004)

Please advise the person who has fallen of the following: The information given and their name and contact details will be sent to Milton Keynes Community Based Falls Prevention Service and a member of the team/partnership may contact them to discuss the fall and arrange an assessment with a Health Care Professional.

Agreement to follow up by a Falls Prevention Partnership Service: ☐ **Yes** ☐ **No**

Name of person referred: **Gender:** ☐ **Male** ☐ **Female**

Date of Birth: **NHS number:**

Address:

Post Code: **Tel:**

Does the person live alone? ☐ **Yes** ☐ **No**

Ethnicity:
- ☐ White British
- ☐ White Irish
- ☐ White & Black African
- ☐ White & Asian
- ☐ White & Black Caribbean
- ☐ Any other White Background
- ☐ Any other Mixed Background
- ☐ Pakistani
- ☐ Bangladeshi
- ☐ Any other Asian Background
- ☐ Indian
- ☐ Chinese
- ☐ Any other Black Background
- ☐ African
- ☐ Caribbean
- ☐ Other Ethnic group
- ☐ Person has chosen not to specify ethnicity

Next of Kin Name: Contact number:

Relationship with Service User:

Surgery Name: GP Name:

Surgery Address:

Post Code: Tel:

Referred by: Print Name Job Title:

Address:

Post Code: Tel:

Email/Signature: Date:

Form continued overleaf...

B-Well Therapy Limited

milton keynes council

B-Well Therapy Limited
Milton Keynes Business Centre
Suite: 131-132 Foxhunter Drive, Linford Wood, Milton Keynes, MK14 6GD.
Telephone: 01908 686751 **Fax:** 01908 686749
Email: spa@mkfalls.co.uk **Website:** www.mkfalls.co.uk

Name of Person Referred: | Date of Birth:

Falls details: | Date of trip/falls:

Details of Falls(time place, falls history. etc.)

Actions/Interventions as a result of this Fall (Hospital/GP/Antibiotics/Injury)

1	Is there a history of any fall in the last year?	☐ **Yes**	☐ **No**
	How many times has the person fallen in the last year?		
2	Does the person take 4 or more different types of medication?	☐ **Yes**	☐ **No**
3	Has the person been diagnosed with Parkinson's Disease?	☐ **Yes**	☐ **No**
	Has the person ever had a stroke?	☐ **Yes**	☐ **No**
4	Does the person report any problems with their balance?	☐ **Yes**	☐ **No**
5	Does the person need to use the arms of the chair to rise from a chair of knee height?	☐ **Yes**	☐ **No**
	Total number of YES answers	**/ 5**	

I	Does the person have memory problems/confusion/difficulty following instructions?	☐ **Yes**	☐ **No**
II	Did the person experience dizziness when s/he fell?	☐ **Yes**	☐ **No**
III	Does the person feel afraid that s/he will fall again?	☐ **Yes**	☐ **No**
	If **Yes**: Where do you scale your fear of falling on a scale of 0 to 10 (0- No fear at all - 10 Terrified of falling)?		
IV	Has the person broken any bones since the age of 50?	☐ **Yes**	☐ **No**
	If so, which bone(s)?		
V	Is the person able to walk across the room?	☐ **Yes**	☐ **No**
	With/without walking aid. With/without assistance		

Medical History (if known)

Medications (if known)

Goals identified/areas of intervention that would be considered beneficial:

Current level of community support

Team	Name & Tel No.	Level of input
Home Care		
Occupational Therapy		
Physiotherapy		
District Nurse		
Social Work		
Team		

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