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| **Integrated Falls and Bone Health Referral**  **Brysson Whyte Rehabilitation Unit Referral**  **EMAIL:** [**stgh-tr.therapyreferrals@nhs.net**](mailto:stgh-tr.therapyreferrals@nhs.net)  **Please attach EMIS if possible and complete all sections** | | | | | | |
| Date of Referral 01/06/2022 | | | | | | |
| IFBHS assesses patients **who meet two or more of the following criteria:**   * Fallen in the **last 12 months,** and/or concerned about falls**.** * Usually independently mobile with/without aid but becoming unsteady * Bone health needs – diagnosed with osteoporosis/osteopenia/recovering from fragility fracture/s   **Exclusion Criteria:**   * Clinical suspicion of acute medical event e.g acute coronary syndrome, CVA, sepsis, GI bleed * Acute mental health problem e.g psychotic episode * Severe cognitive impairment (unable to follow simple instructions) * Assistance of 2 for transfers, unable to mobilise and bed bound patients * Under the care of palliative team   If the client has been seen by our team in the last 6 months, they must have a significant change in function or mobility for a new referral to be accepted.  **PLEASE NOTE: We are not an urgent care service and do not have weekend cover.**  Referrals will be prioritised by the screening therapist according to the information on the referral from. Any information omitted may affect prioritisation. **Please complete all sections of the referral, if this is not done, it will be rejected and returned to the referrer.**  **To discuss referrals and for up to date information of waiting times please call the screening therapist on:** 020 8725 8064 | | | | | | |
| **Male  Female** | | | | | Date of Birth: Click here to enter a date. | |
| Title | Given Name: | | | | Family Name: | |
| Mr | Click here to enter text. | | | | Click here to enter text. | |
| Patents Address: Click here to enter text.  Post Code: Click here to enter text.  Tel No. 0Click here to enter text.  NHS No. Click here to enter text. | | | GP Name: Click here to enter text.  GP Surgery: Click here to enter text.  GP Tel No. Click here to enter text.  Referred by: Click here to enter text.  Does the patient need a Physiotherapist  **and/or** an Occupational Therapist | | | |
| **Reason for Referral:** Click here to enter text.  Please note the screening therapist will deem the urgency of this referral, so please provide as much information as possible to help with the screening process. In your opinion is this referral: **URGENT**  Reason why you think it is Urgent: Click here to enter text. OR Routine/ MEDIUM  Routine/ LOW  Class/Group Referral | | | | | | |
| **Past Medical History:** Click here to enter text.  EMIS attached:  Is this patient medically stable? Yes  No  If no, comments: Click here to enter text.  BP issues? Yes  No  Comments: Click here to enter text.  Impaired Vision? Yes  No  Comments: Click here to enter text.  Impaired hearing? Yes  No  Comments: Click here to enter text. | | | | **Recent admission to hospital?**  Yes  No  Date Click here to enter text.  Date of discharge: Click here to enter text.  Hospital SGH | | |
| **Bone Health:**  Diagnosis of: **Osteoporosis**   **Osteopenia**  Comments: Click here to enter text.  **Previous fragility fracture:** Yes  No  Date of fracture: Click here to enter text. | | | | | | |
| **Social Situation:** Click here to enter text.  Lives alone: Yes  No  Lives with: Click here to enter text.  House  Flat  Sheltered Accommodation  Care Home  Comments: Click here to enter text.  Is this patient housebound? Yes  No  Will they need transport to appointments? Yes  No  Is a POC in situ? Yes  No  Care Agency? Click here to enter text.  Known to Social Services?  Known Social Worker?  If Yes, Contact details: Click here to enter text.  Do they need an increase in POC? Yes  No  If Yes, have you referred on? Yes  No  Comments: Click here to enter text.  Any safety concerns for staff visiting at home? Yes  No  If yes, comments: Click here to enter text.  Safeguarding concerns? Yes  No  If yes, comments: Click here to enter text. | | | | | | |
| **Next of Kin:** | | **Has the patient been referred to other services Yes  No** | | | |
| Relationship: Click here to enter text.  Tel No.  Patients has consented to referral:  Yes  No  Interpreter Needed:  Yes  No  Language: Click here to enter text.  NOK will Interpret: Yes | | **If yes which one/s**? D2A  Maximising Independence  Podiatry  District Nurses  Falls Clinic  Senior Health Clinic  Palliative care teamDementia CNS Social services OT  Other: Click here to enter text.  **Diagnosis of Dementia:** Yes  No  if yes please date: Click here to enter a date.  Comments (behavioral): Click here to enter text.  Known to Memory Clinic? Yes  No  Known Delirium?  Acute confusion? Yes  No | | | |
| Referred by: Designation: OT Tel No. | | | | | |
| **Referral Criteria:**  We accept referral for patients living in the Wandsworth borough or with GPs in the borough of Wandsworth  Any patients with postcode of SW15 will be forwarded to the Brysson Whyte Rehabilitation Unit team, which accepts patients with the GPs in the boroughs of Wandsworth and Richmond.  **The following groups are run which may be offered following an assessment:** falls, strength and balance groups at different locations around the borough, Bone Health Classes, Parkinson’s disease group at the Brysson Whyte Rehab Unit, outdoor mobility groups at both St John’s Therapy Centre and Brysson Whyte Rehab Unit.  Please contact us on **020 8725 8064** if you require further advice. | | | | | |