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| **Integrated Falls and Bone Health Referral** [ ] **Brysson Whyte Rehabilitation Unit Referral** [ ] **EMAIL:** **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 [x]  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 team[ ] Dementia 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. |