SLIC Falls Pathway Telephone Screening Form

Date and Time of call:

Demographic details

Name:	**DOB**:
Contact Tel No: **Mobile Tel No:** **Email:** **Happy for texts & Emails?** ☐ Yes ☐ No	**NOK Details:** **NOK Contact No:** **Residency**: ☐ Lambeth ☐ Southwark
Address: **Postcode:** **GP Name:** **Contact No:**	**NHS No:** **Ethnicity (if not already recorded on Carenotes)**

Referral Source:

Self Referral ☐ How did you hear about us?
Poster ☐ Poster location:
Leaflet ☐ Leaflet location:
Video advert ☐ Advert location:
Other:

Other Service ☐ Service Name:

Referrer Name (if GP/nurse doc Practice): Contact No:

Recent Holistic Health Ax? ☐ Yes ☐ No ☐ Not sure
If Y record 'HHA' as referrer name on spreadsheet

CareNotes review (check referrals screen and progress notes)

Is client already known to the service? ☐ Yes ☐ No
- If Yes describe, incl. when seen and by whom::

Any further action required? ☐ Yes ☐ No

Falls history

1. Have you had any falls in the last 12 months? * ☐ Yes ☐ No (if no see Q2)
   - If Yes how many?*:
   - Do you know what happened when you fell?* ☐ Yes ☐ No ☐ N/A
     * If Yes describe*:
   - Have your falls been investigated? (GP/A&E/Clinic)* ☐ Yes ☐ No ☐ N/A
   - Did you feel dizzy before you fell?* ☐ Yes ☐ No ☐ N/A
   - Did you black out? (Did you remember hitting the floor)* ☐ Yes ☐ No ☐ N/A
2. Are you frightened of falling?* ☐ Yes ☐ No

If Yes to blackout or dizziness or if client has had two or more unexplained and un-investigated falls in last 12 months refer to Falls Clinic

Name: **DOB:**

Mobility & physical function

1. Do you use a walking aid indoors? ☐ Yes ☐ No
   - If Yes what is it and how do you manage to mobilise indoors?
2. Do you walk without physical help from another person? ☐ Yes ☐ No
3. Do you feel unsteady when walking? ☐ Yes ☐ No
4. Can you get up from a chair without physical help? ☐ Yes ☐ No
5. Can you get up and down a flight of stairs at the moment? ☐ Yes ☐ No
   - If yes, do you find this difficult? ☐ Yes ☐ No
   - Do you need to use rails? ☐ Yes ☐ No
   - Could you use stairs in an emergency? ☐ Yes ☐ No
6. Can you stand without holding onto anything for 30 seconds? ☐ Yes ☐ No
7. Do you get and about at the moment? (shops/GP/podiatry/bus/driving etc) ☐ Yes ☐ No
   - What walking aid do you use outdoors?
8. How far can you walk before you need to stop?
9. Could you get to and from a class? (consider buses/taxi card/dial a ride) ☐ Yes ☐ No

Social history:

Do you have any difficulties managing daily activities at home? (e.g. washing, bathing, toileting, dressing, cooking, shopping) ☐ Yes ☐ No

- If Yes describe incl. any previous Rx, equipment, help from carer/family etc

If YES and difficulties haven't been addressed consider referral to OT/Social Services

Name: **DOB:**

Medical History and Drug History – See GP medical summary attached		
Medical Considerations		
Do you feel safe and able to exercise in a class?	☐ Yes	☐ No
Heart Problems (e.g. angina, heart disease, arrhythmia) If Yes, comments, incl. whether client uses GTN spray:	☐ Yes	☐ No
Circulatory Problems (e.g. hypertension, postural hypotension) If Yes, comments:	☐ Yes	☐ No
Previous Fractures (e.g. UL, LL, vertebral) If Yes, comments incl. when and whether it was a traumatic # or fragility #:	☐ Yes	☐ No
Lung Problems (e.g. smoking, breathlessness on exertion, COPD, asthma) If Yes, comments incl. whether client uses inhalers:	☐ Yes	☐ No
Diabetes Mellitus If Yes,comments incl. whether it is controlled with diet, medication or insulin	☐ Yes	☐ No
Cancer If Yes, comments:	☐ Yes	☐ No
Back / neck problems (e.g OA, pain, stenosis, surgery) If Yes, comments:	☐ Yes	☐ No
Leg problems (e.g. OA, joint replacement, pain) If Yes, comments:	☐ Yes	☐ No
Arm problems (e.g OA, joint replacement, pain) If Yes, comments:	☐ Yes	☐ No
General dizziness If Yes, comments incl whether has been addressed by GP/hospital:	☐ Yes	☐ No
Visual problems If Yes, comments:	☐ Yes	☐ No
Hearing problems If Yes, comments:	☐ Yes	☐ No
Any other additional relevant info or special considerations:		

Name: **DOB:**

Summary of client's current difficulties (incl. impression of cognitive ability, ability to participate in exercise, and whether other services are needed):

Discussed with qualified physio? ☐ Yes ☐ No

Outcome and treatment decision:

Straight to community class	☐	**1:1 OT for rehab**	☐
Face to face triage appointment	☐	**1:1 Otago**	☐
Healthy lifestyle information	☐	**Strength & Balance Group**	☐
Falls clinic	☐	**Social Services OT**	☐
1:1 Physio	☐	**Social Services for care package**	☐
No further falls action (please see below)	☐		

Reason for outcome and treatment decision including goals:

If suitable for community class:

First choice of venue:

Second choice of venue:

Preferred day of the week to attend:

If there is no further falls action following triage:

Already receiving treatment elsewhere	☐	**Client out of area**	☐
Just completed treatment elsewhere	☐	**Client medically unfit**	☐
Declined input (& not approp. for class)	☐	**Needs different services**	☐
Declined input (but approp. for class)	☐	**Unable to contact**	☐

Has the referral been discussed with the person and do they agree to it and to sharing their information?* ☐ Yes ☐ No

Name and role of person completing screen: **Date:**