

Falls Service Referral Form

Date Referral Received: _____

Name: _____

Address: _____ Post Code: _____

Tel No: _____ H&C No: _____

DOB: _____ GP: _____

GP Address: _____

Medication List (or attach)

Past Medical History:

History of cognitive impairment?

Yes / No

If Yes is this patient know to the Memory Team?

Yes / No

Details: _____

Brief History of Fall: _____

Can the patient easily explain the fall? Yes / No

Any dizziness, light headedness, loss of consciousness? Yes / No

Injuries sustained? Yes / No

Details if known: _____

No of Falls in last year: _____

Any features suggestive of loss or altered level of consciousness? Yes / No

Referred by: (PRINT) _____ Signed: _____

Designation of Referrer: _____ Date: _____

Contact No of Referrer: _____

Has client consented to referral? Yes / No

FOR OFFICIAL USE ONLY

Patient Centre / PAS detail Level 2

Level 3

N & M Locality: Falls Clinic, Bramblewood, Drumalane Complex, Drumalane Road, Newry BT34 8AP
fallsteam.newry@southerntrust.hscni.net

A & D Locality: Falls Clinic, Mullinure Health and Wellbeing Centre, Loughgall Road, Armagh BT61 7NQ
fallsteam.armagh@southerntrust.hscni.net

C & B Locality: Falls Clinic, Lurgan Day Hospital, Sloan Street, Lurgan BT66 8NX
fallsteam.lurgan@southerntrust.hscni.net