

HEREFORDSHIRE FALLS PREVENTION SERVICE SELF REFERRAL FORM

Person Details

Name:

Address:

D.O.B.

Tel No (Home):

GP Surgery:

Are you currently involved with another service, e.g. Neighbourhood Team? If so please give details;

Do you consent to the Falls Prevention Service contacting your GP? Yes No

		YES	NO
1.	Have you fallen in the previous 12 months? Number of falls in past 12 months		
2.	Do you have any near misses, i.e. near falls?		
3.	Do you have a fear of falling?		
4.	Do you have any problems with your balance?		
5.	Are you on four or more different medications per day?		
6.	Do you have a diagnosis of stroke or Parkinson's disease?		
7.	Do you suffer from dizziness?		
8.	Do you suffer from blackouts or fainting?		

Past Medical History:

If you have a history of head injury, seizure or chest pain associated with a fall, or a recent injurious fall, blackout or unexplained fall please inform your GP.

Please send all completed forms to:

Falls Prevention Service
Leominster Community Hospital
South Street
Leominster
HR6 8JH

Tel No: 01568 617309
Fax No: 01568 617306
E-mail: fallsreferrals@nhs.net
Website: www.wyevalley.nhs.uk
(services > community services > falls)