

FALLS PREVENTION CLINIC – PATIENT REFERRAL

175 – 828 W. 10th Ave. Vancouver, BC V5Z 1L8
P: 604-875-4111 loc. 69611 F: 604-875-5129
www.fallsclinic.com

FOR CLINIC USE ONLY: Appt Date: _____ Appt Time: _____
--

Date: _____

Patient's Name: _____ Age: _____

PHN: _____ Date of birth: _____

Phone: _____

Address: _____

Family Physician: _____ MSP# _____

Phone: _____ Fax: _____

Reason for Referral: _____

Referring Clinician: _____

To best serve your patient, please fax the following information to **604-875-5129** as soon as possible.

A. Patient Eligibility - *Please ensure your patient is eligible for our clinic by checking the following:*

This Patient:

- Is aged 70 years or over
- Has had at least 1 fall in the previous 12 months (Number: ____ Indoor Outdoor Both)
- Has not had a hip fracture or hip replacement in the previous 2 years
- Has not been diagnosed with a progressive neurological condition (*E.g., Multiple Sclerosis, Parkinson's disease, etc.*)
- Has reasonable cognitive function, and has not been diagnosed with Dementia or Alzheimer's Disease (MMSE score of 24 or higher)
- Is community-dwelling (including assisted living facilities) in the Vancouver, Richmond, Burnaby, North/West Vancouver area
- Is ambulatory (with or without assistive device)
- Can verbally communicate well in English
- Has a life expectancy of >1 year

B. Current medication list (Name and Dosage)

C. Please list any other relevant information or diagnoses: _____

D. PLEASE ATTACH: Bone density reports, recent test results, consult reports (esp. Internal Med or Geriatrics), hospital discharge summaries, etc.

Thank you for your referral