Western Health

WHCOR401

Falls and Fracture Clinic Referral Form

Level 4, Western Centre for Health Research and Education
Sunshine Hospital, 176 Furlong Road St Albans VIC 3021.
Phone: (03) 8395 8231 Fax: (03) 9923 6624

Hospital UR#.....
Name: .....
Address: .....
Suburb: .....
Postcode: ..... Telephone: .....
DOB:_____/_____/_____Marital Status:

Please fax referral to (03) 9923 6624 or send via email to whs-aimss@wh.org.au

GP Name: ..... **Provider Number:** .....
Clinic Name: .....
Address: ..... **Suburb:** .....
Postcode: ..... **Ph:** ..... **Fax:** .....
Is GP aware of Referral ☐ Yes ☐ No **Has the patient consented to this Referral:** ☐ Yes ☐ No

Carer Availability	**Carer Relationship**	**Living Arrangements**	**Accommodation**
☐ No Carer	☐ Spouse/Partner	☐ Lives Alone	☐ Private (own/rent/purchase)
☐ Co-resident Carer	☐ Parent	☐ Lives with Family	☐ Outreach
☐ Non Resident Carer	☐ Child/Child in law	☐ Lives with Others	☐ Supported Community
	☐ Other Relative	☐ Not stated	☐ Residential Aged Care
	☐ Friend/Neighbour		☐ Residential Care Facility (not aged)
	☐ Foster Carer		☐ Other Accommodation

Country of Birth: Aboriginal or Torres Strait Islander ☐ Yes ☐ No

Medicare No: DVA No (if applicable):

Required Criteria (must tick all)
- ☐ Aged 65 and over
- ☐ No serious memory deficits
- ☐ Able to mobilise with frame or stick(s)
- ☐ Patient consent/willing to attend

Presentations (please tick all which apply)
- ☐ Multiple faller (>2 within last 12 months)
- ☐ Single faller with established gait and/or balance deficit
- ☐ Fall due to loss of consciousness
- ☐ Unexplained fall with apparent complex medical cause
- ☐ History of symptomatic or asymptomatic fragility fracture
- ☐ Clinical or paraclinical (BMD) risk of fractures

DXA Scan Required? ☐ Yes ☐ No

Note to GPs: *To assist with the Falls and Fractures Clinic assessment, please attach patient details including the history, relevant pathology results, list of medications and other relevant information such as existing care plans.*

Client Agreement: I ..... (client name) agree:

- To participate in the Falls and Fracture Clinic program
- That **information about my medical condition and care needs** can be supplied to the staff of these programs and the services providing assistance to me, including my local doctor,
- That the staff may **feed back to the hospital staff** about my recovery and the care needed

SIGNED: ..... (client) DATE: .....

CARER / GUARDIAN CONSENT
If the client is unable to give informed consent the guardian or a carer may sign on his/her behalf.

SIGNED: ..... (carer) DATE: ..... RELATIONSHIP: .....