

REFERRAL FORM

Fall Prevention Patient Referral

PATIENT INFORMATION

Patient:	Referred to:
Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female DOB: / /	
Address:	Address:
Phone:	Phone:
Email:	Email:
Diagnosis:	

TYPE OF REFERRAL

Type of specialist:

Exercise or fall prevention program:

Additional recommendations:

REASON FOR REFERRAL

<input type="checkbox"/> Gait or mobility problems	<input type="checkbox"/> Medication review & consultation
<input type="checkbox"/> Balance difficulties	<input type="checkbox"/> Inadequate or improper footwear
<input type="checkbox"/> Lower body weakness	<input type="checkbox"/> Foot abnormalities
<input type="checkbox"/> Postural hypotension	<input type="checkbox"/> Vision <20/40 in <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both
<input type="checkbox"/> Suspected neurological condition (e.g., Parkinson's disease, dementia)	<input type="checkbox"/> Home safety evaluation led by occupational therapist

Other reason:

Other relevant information:

Referrer signature: _____

Date: _____



Centers for Disease
Control and Prevention
National Center for Injury
Prevention and Control

STEADI Stopping Elderly Accidents,
Deaths & Injuries