north simcoe family health team

North Simcoe Family Health Team
Fall Prevention Program

Fall Prevention Program Referral

Client Information
Name:
DOB:
HCN:
Address:

Phone #:

Date of Referral:
Family Physician:
Referred by:
Client aware of referral ☐ Yes ☐ No
Best Person to Contact:
Relation of contact person:
Contact Phone Number:

This patient is being referred for (only pick ONE):

- ❑ Individualized comprehensive assessment of fall risk factors
- ❑ Group education session on fall prevention

This patient is being referred due to one or more of the following:

- ❑ A fall or near-fall within the past 6 months
- ❑ Concern or fear of falling
- ❑ Changes in mobility or balance, or concerns regarding either
- ❑ A chronic medical condition affecting balance
- ❑ Other:
  _____
  _____

Medical History: (Please share diagnoses and relevant medical history)

Additional relevant information:

INTERNAL REFERRALS (FHT): PLEASE SEND COMPLETED REFERRALS AS A TASK TO THE NSFHT SENIORS PROGRAM TEAM
EXTERNAL REFERRALS: PLEASE FAX COMPLETED REFERRALS TO (705) 526-1205