FALLS PREVENTION CLINIC – PATIENT REFERRAL

5th floor- 2635 Laurel Street. Vancouver, BC V6H 3Z6
P: 604-875-4111 loc. 52578 F: 604-875-5129
www.fallsclinic.ca

Date: _____

Patient's Name: _____ **Age:** _____

PHN: _____ **Date of birth:** _____

Phone: _____

Address: _____

Family Physician: _____ **MSP#** _____

Phone: _____ **Fax:** _____

Referring Clinician: _____ **MSP#** _____

Phone: _____ **Fax:** _____

Reason for Referral: _____

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 ≥ 65 years old
- ☐ Had ≥ 1 fall in the prior 12 months (Date of most recent fall: _____)
  - * ☐ **Cause of Fall** (☐ Syncope ☐ Non- Syncope ☐ Explanation: _____)
- ☐ Not diagnosed with a progressive neurological condition *(E.g., Multiple Sclerosis, Parkinson's disease, etc.)*
- ☐ 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 Greater Vancouver area
- ☐ Is ambulatory (with or without assistive device)
- ☐ 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.

☐ Patient would like to be place on our cancellation list while maintaining a place on our waitlist