**WEST END INTEGRATED FALLS PREVENTION PROGRAM**

**Phone: 613-820-4922 Fax: 613-288-3407**

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| **REFERRAL CRITERIA : Please check that client meets ALL criteria** | | |
| o At least 1 indoor or multiple outdoor falls in the past year    o 75 years of age or older  o Live in their own home or in a retirement home, NOT living in long term care facility  o Able and motivated to take action to reduce falls | o NOT currently receiving duplicating services with The Home & Community Care Support Services *(formerly known as the Champlain LHIN)* for therapy services or the Geriatric Day Hospital/Clinic  o Client/caregiver is aware of and consents to referral | |
| **Client information** | | |
| **Name:** | **DOB:** (yyyy/mm/dd) | **Gender:** |
| **Street address:**  \*This program is only funded for certain areas in the West end of Ottawa | **City:** | **Postal code:** |
| **Phone(s):** | **Preferred Language:** | |
| **Cognition** | | |
| **Has the client been diagnosed with a cognitive impairment?**  o No o Do not know | | |
| o Yes - Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Caregiver is available to attend all appointments** o Yes o No  Caregiver’s name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| **FALLS** | | |
| **Number of indoor falls:** 0 1 2 3 4 5+ | **Number of outdoors falls:** 0 1 2 3 4 5+ | |
| **Brief description of fall(s):** | **Brief description of fall(s):** | |
| **PAST MEDICAL HISTORY** | **MEDICATIONS** | |
|  |  |  |
| **Primary Care Provider** | | |
| **Name:** | **Phone:** | **Fax**: |
| **Street address :** | **City:** | **Postal Code:** |
| **Referral source** o Primary care provider as above | | |
| **Name and Title:** | **Phone:** | **Fax:** |
| **Organization:** | **Date of Referral:** | |

**Incomplete referrals will be returned to the referral source**