

## FALLS PREVENTION PROGRAM Referral Form

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 Tel: 416-224-6948 | Fax: 416-226-3358  
[www.sunnybrook.ca/stjohnsrehab](http://www.sunnybrook.ca/stjohnsrehab)

PATIENT'S NAME:		D.O.B.: YYYY / MM / DD	OHIP NUMBER: (Include Version Code)	
PATIENT'S ADDRESS:			PHONE #:	
CAREGIVER NAME/CONTACT INFO:		LANGUAGES: REQUIRES INTERPRETER: <input type="radio"/> YES		<input type="radio"/> MALE <input type="radio"/> FEMALE

CURRENT PRIMARY DIAGNOSIS: \_\_\_\_\_

DATE OF SURGERY/TYPE: \_\_\_\_\_

**MEDICAL HISTORY:**

- |  |  |  |
|--|--|--|
| <input type="radio"/> Hypertension         | <input type="radio"/> Stroke: Type: _____  | <input type="radio"/> History of Falls       |
| <input type="radio"/> Pacemaker            | <input type="radio"/> Seizures   | <input type="radio"/> Osteoporosis           |
| <input type="radio"/> Vascular Disease     | <input type="radio"/> Diabetes: <input type="radio"/> Type 1; <input type="radio"/> Type 2 | <input type="radio"/> Fractures: _____       |
| <input type="radio"/> Other Cardiac: _____ | <input type="radio"/> Cancer: Type: _____  | <input type="radio"/> Arthritis: Type: _____ |
| <input type="radio"/> Other: _____         |  |  |

ISOLATION REQUIREMENTS (MRSA, VRE, etc.):  Yes  No, Organism/Location: \_\_\_\_\_

CONTRAINDICATIONS: medical or psychiatric instability, cognitive impairment, complex needs requiring active in-home or inpatient services, lives > 1 hour drive from the hospital

**REASON FOR REFERRAL & SERVICES REQUIRED:**

*Please specify the patient issues (as many as relevant) that require the following services:*

- |   |   |
|---|---|
| <input type="radio"/> Recent falls                  | <input type="radio"/> Dizziness and/or fainting spells  |
| <input type="radio"/> Decreased mobility            | <input type="radio"/> Taking > 4 prescribed medications   |
| <input type="radio"/> Poor balance                  | <input type="radio"/> Taking ≥ 1 high risk medications for falls<br>(e.g. benzodiazepines, opioids, psychotropics, anticholinergics, diuretics, etc.) |
| <input type="radio"/> Leg weakness                  | <input type="radio"/> Other issue(s): _____   |
| <input type="radio"/> Difficulty managing self-care |   |
| <input type="radio"/> Poor vision                   |   |

**Interprofessional Assessment Includes:**

- Assessment by an Occupational Therapist and a Pharmacist at patient's residence
- Physiotherapy Assessment for participation in a group exercise program at St. John's Rehab
- Group Education Session on site by a Physiotherapist and Dietitian
- Social Worker Assessment

REFERRING PHYSICIAN'S NAME/SIGNATURE: \_\_\_\_\_ / \_\_\_\_\_

REFERRING PHYSICIAN'S PHONE #: \_\_\_\_\_ FAX #: \_\_\_\_\_

REFERRING FACILITY: \_\_\_\_\_ DATE OF REFERRAL: \_\_\_\_\_