Sunnybrook
ST. JOHN'S REHAB

FALLS PREVENTION PROGRAM
Referral Form

285 Cummer Avenue, Toronto, ON M2M 2G1
Tel: 416-224-6948 | Fax: 416-226-3358
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: ❍ YES	❍ MALE ❍ FEMALE

CURRENT PRIMARY DIAGNOSIS: ______________________________

DATE OF SURGERY/TYPE: ______________________________

MEDICAL HISTORY:

- ❍ Hypertension
- ❍ Pacemaker
- ❍ Vascular Disease
- ❍ Other Cardiac: ______________
- ❍ Stroke: Type: ______________
- ❍ Seizures
- ❍ Diabetes: ❍ Type 1; ❍ Type 2
- ❍ Cancer: Type: ______________
- ❍ History of Falls
- ❍ Osteoporosis
- ❍ Fractures: ______________
- ❍ Arthritis: Type: ______________
- ❍ 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:

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

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:** ______________________

Please refer to Falls Prevention Program brochure or website for inclusion/exclusion criteria and other information
www.sunnybrook.ca/stjohnsrehab/falls