**OTAGO SELF-REFERRAL FORM**

**If you have trouble completing forms, please call us on 0330 380 1013 and we will be able to help you.**

|  |  |
| --- | --- |
| Name: | |
| Address: | |
| Phone Number: (Home) | (Mobile) |
| Email: | |
| Date of Birth: | NHS No: (If Known) |
| Next of Kin: | |
| Next of Kin contact details: | |
| Date: | |

|  |
| --- |
| GP Name: |
| GP Practice: |
| GP Phone: |
| Please give us permission to contact your GP to check that this exercise programme is suitable for you? **Yes  No**  Please call us if you want to discuss this. |

**Please tell us about any falls you have had**

How many falls in the last year? **1 2-3 More than 3**

Did you injure yourself in any of these falls? Please tell us about your injuries:

|  |
| --- |
|  |

Have you been checked for the reason for any of your falls? Please tell us about the results of any investigations:

|  |
| --- |
|  |

Do you worry about having a fall or feel unsteady on your feet? **Yes  No**

Do you have a diagnosis of osteoporosis/osteopenia (fragile or brittle bones)

**Yes  No**  **Don’t Know**

Would you be able to follow an exercise programme for the next 6 months and practice at home?

**Yes  No**  **Don’t Know**

Is there someone at home or in your family who could help you with the programme?

**Yes  No**  **Don’t Know**

Please tell us about how you get around the house:

**Without help**  **Stick/Crutch**  **Frame/Walker**

Can you manage stairs: **Yes**  **No**  **With help**

Do you have space in your home to exercise: **Yes  No**

Please use this space if you want to tell us anything else:

**Please return this form to:**

MRS Independent Living, The Adiaha Antigha Centre, 24-30 Dalston Lane, London E8 3AZ

Or by email: [otago@mrsindependentliving.org](mailto:otago@mrsindependentliving.org)