**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