**Staying Steady**

**Community-based Strength and Balance Classes for Falls Prevention**

**Referral Form**

This programme lasts for 24 weeks and takes place in community centres, sports halls and health centres around Hackney. It has been designed to prevent falls in people with balance difficulties and decreasing muscle strength. It will not meet the needs of people with other problems. Please exclude other possible diagnoses before referral.

***The service will accept other documentation that answers questions below.***

**IMPORTANT!!! Please ensure** the client has **consented** to this referral.

Consent obtained: **YES**  **NO**

Please check the following inclusion and exclusion criteria before submitting referral.

Please note: **Unless all EXCLUSION CRITERIA** have been crossed as not being applicable, the client will not be suitable for the exercise classes

|  |  |  |  |
| --- | --- | --- | --- |
| **INCLUSION:**  **PLEASE TICK:** | √ | **EXCLUSION: PLEASE CROSS TO CONFIRM THE CLIENT DOES NOT HAVE ANY OF THE FOLLOWING:** | **x** |
| Identified risk of falls |  | Unstable or uncontrolled heart disease |  |
| Identified balance deficits |  | Tachycardia or uncontrolled arrhythmia |  |
| Diagnosis of Osteoporosis/Osteopenia |  | Advanced Parkinson’s Disease |  |
| Ability to participate and follow instructions |  | Acute stroke |  |
| Controlled/stable medical Condition(s) |  | Unmanaged pain |  |
| Motivated to exercise and commitment to long term course (24 sessions) |  | Severe breathlessness or dizziness |  |
| Able to support themselves upright in a chair |  | Recent Injurious fall, which has not been examined and investigated |  |
| Able to mobilise 10m with appropriate walking aid. |  | Unresolved medical reason for fall |  |
| Able to independently stand and transfer |  | Acute systemic illness (e.g. active viral illness, cancer) |  |
| Able to organise own travel (help with community transport application can be provided) |  | Cognitive impairment such that client is unable to follow simple instructions |  |

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| --- | --- |
| **CLIENT’S NAME:** | |
|  | |
| **CLIENT’S ADDRESS** | |
|  | |
|  | |
|  | |
| **Postcode:** | **Phone:** |
| **DOB: / / Age:** |  |
| **Gender: male**  **female** |  |
| **Ethnicity:** | |
| **Next of kin:** | |
| **Phone:** | |
| **GP NAME:** | |
| **GP PRACTICE & PHONE No:** | |
| **History of presenting condition?** | |
|  | |
|  | |
| **Number of falls in the last year: 1**  **2**  **3** frequent faller | |
| **Have the falls been investigated?**  YES  NO  N/A | |
| If **YES,** please give summary of the outcome**;** If **NO** or **N/A,** tell us **WHY:** | |
|  | |
| **Objective measurements:** (Physiotherapists please supply test results)  **Date of the most recent test……………………………………………………**  Timed Up and Go:…………………….seconds  Turn 180’:………………………………steps  Functional Reach:……………………..centimetres  **Fear of falling:** no fear = 1-2-3-4-5-6-7-8-9-10 = very anxious (circle one number) | |
| **Is the client able to follow instructions**  **and memorise tasks? YES**  **NO**  **with limitations** | |
| If the service user has **cognitive limitations**, please explain their difficulties: (please note that only people at an early stage of dementia can be accepted on the PSI programme): | |
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|  | |
| **Medical History:** | |
| CHD  Hearing impairment  Foot deformities | |
| Osteoporosis  High BP  Previous fractures  if yes, | |
| Asthma/COPD  Angina  specify which bone and when: | |
| Joint replacement  Arthritis | |
| Diabetes  Visual impairment  Other: | |
| **Other comments regarding medical history:** | |
|  | |
|  | |
| **List of current medication(s):** | |
|  | |
| **MOBILITY and living arrangements:** | |
| - Lives alone  Can use stairs | |
| - Uses walking stick (how many)  Walks outside | |
| - Uses walking frame | |
| **Other precautions and special considerations:** | |
| **Staying Steady cannot provide transport to and from the classes this will need to be made clear to the client before the referral is made.** | |
| **REFERRER NAME & DESIGNATION:** | **REFERRER CONTACT DETAIL:** |
|  | **Email:** |
|  |  |
|  |  |
| **PHONE No:** | **DATE OF REFERRAL:** |
|  |  |

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

**Or email:** [**stayingsteady@mrsindependentliving.org**](mailto:stayingsteady@mrsindependentliving.org)