Please fax referrals to: 03 477 1168 or 0800 477 116

or email: bwellfallsandfractureteam@wellsouth.org.nz

**REFERRAL TO B-WELL FALLS AND FRACTURE PREVENTION TEAM**

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| --- | --- | --- |
|  Surname:  | First name:  | Ethnicity:  |
| Patient NHI:  | Patient DOB:  | Patient phone number:  |
| GP: | GP Practice: |
| Patient address: *Please indicate any known risks to contacting or visiting this patient e.g. ability to hear/answer phone, intimidating pets etc.* |

|  |  |
| --- | --- |
| Referred by:  | Date:  |
| Your designation:  | Organisation:  |
|  |

**Service requested** (please select all options that apply)

Home-Based Falls Prevention*(For patients aged 75 and over, or 65 and over if Maori or Pasifika)*: 

Fracture Liaison Service *(For patients over 50):*  

|  |  |  |
| --- | --- | --- |
| **Consent:** Patient consents to this referral and contact by the B-Well Team | **Yes**  **No ** | **No**  |
| Patient already receiving Physiotherapy or other rehabilitation service | **Yes**  | **No**  |
| Patient living in Rest Home or Hospital Level Care | **Yes**  | **No**  |

***Complete if for Fracture Liaison Service or both services:***

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| --- |
| **Fracture History:** *For patients aged 50 and over* |
| Patient sustained a fragility fracture / caused by a low force event\* | **Yes**  | **No**  |
| Fracture date:  | Fracture site:  |
| Zoledronic Acid (Aclasta) infusion given? If yes, date: | **Yes**  | **No**  |

*\*A fracture occurring spontaneously or following a minor trauma such as a fall from a standing height or less*

***Complete if for Home-Based Service or both services:***

|  |
| --- |
|  **Falls History: 3 Key Questions to ask patient** |
| **1)** Have you slipped, tripped, or fallen in the last 12 months? | **Yes**  | **No**  |
| **2)** Can you get out of a chair without using your hands? | **Yes**  | **No**  |
| **3)** Have you avoided some activities because you are afraid you may fall? | **Yes**  | **No**  |
| Are you concerned about this patient’s gait, strength, or balance? Additional details: | **Yes**  | **No**  |
| Can this patient mobilise outside their home/access the community? | **Yes**  | **No**  |
| Please provide any conditions which may impact this patient’s ability to participate in prescribed home or group-based exercise, e.g. incontinence, cognitive impairment, or other medical condition? |

Thank you for your referral. For further information or to discuss this referral further, please contact the B-Well Falls and Fracture Prevention Team via bwellfallsandfractureteam@wellsouth.org.nz

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