



Queensland
Government

**Wide Bay Hospital and Health Service
Integrated Care Services**

**WIDE BAY FALL
PREVENTION SERVICE
Referral Form**

Hervey Bay
Bundaberg

Maryborough
.....

(Affix identification label here)

URN:

Family Name:

Given Name(s):

Address:

Date of Birth:

Sex

M

F

I

Date: .

QAS Incident Number:

Patient's verbal consent

I have explained the Wide Bay Fall Prevention Service to the patient. They understand that the below and additional information will be provided to the service. They are aware that a Nurse will contact them within 2 business days.

Patient details

Name:

Address:

Daytime Contact Number:

Date of Birth:

Age:

Gender:

M

F

I

Does the patient identify as:

Aboriginal

Torres Strait Islander

Not stated / unknown

Aboriginal AND Torres Strait Islander

NOT Aboriginal or Torres Strait Islander

General Practitioner:

Does the patient meet criteria?

- Over 65 years of age or 50 years of age for Aboriginal and Torres Strait Islander people **and**
- Lives in a community dwelling (including retirement villages) **and**
- Experiences a fall (including a slip, trip or stumble) at home or in the community

Not

- Related to chronic alcohol and other drug use
- A fall that occurred as an inpatient
- Living in a Residential Aged Care Facility

Brief history of events:

Treatment/Action taken:

Name:

Designation/Organisation:

Signature:

Date:

Office Use

Email Referral to: WBHHS-ICS-Falls-FC@health.qld.gov.au & WBHHS-ICS-Falls-BBH@health.qld.gov.au

Date received:

First Contact (date and time):

Name:

Designation:

Signature:

DO NOT WRITE IN THIS BINDING MARGIN

WIDE BAY FALL PREVENTION SERVICE REFERRAL FORM

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