



# Fall Prevention Network

Slips and Falls Can Be Prevented

### Mail or fax form to:

Fall Prevention Network  
363 South Harlan St, Suite 200  
Denver, CO 80226  
Phone: 303-922-5555  
Fax: 303-922-7335

## Referral Request Form

The information you provide will be kept confidential and will not be added to any list(s).

### How did you hear about us?

- Television
- Internet search
- Presentation (specify location) \_\_\_\_\_
- Other (specify) \_\_\_\_\_
- Senior Source Website
- Brochure
- Community Event (specify) \_\_\_\_\_
- Fall Prevention Network Website
- Newspaper (Name) \_\_\_\_\_

### Your Contact Information

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Phone number during business hours (please include area code): \_\_\_\_\_

Alternate Phone Number (Please include area code): \_\_\_\_\_

Best time to call (during business hrs): \_\_\_\_\_

Home Address: Street \_\_\_\_\_ Apt/Suite/Unit \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

How would you like us to follow-up with you?  e-mail  Phone  Alternate Phone

### Who are you requesting the referral information for?

Self - use my contact information above. (SKIP to next section)

Someone else - use contact information below. Relationship to you:  Family member  Friend  
 Client  Other \_\_\_\_\_

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Phone number during business hours (please include area code): \_\_\_\_\_

Alternate Phone Number (Please include area code): \_\_\_\_\_

Best time to call (during business hrs): \_\_\_\_\_

Home Address: Street \_\_\_\_\_ Apt/Suite/Unit \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**Please answer the rest of questions (below and next page)  
on behalf of the person who will receive the fall prevention services.**

### Fall History

1. Within the past year has he/she had a fall?  Yes  No - GO TO #4
2. Within the past year about how many times would you say he/she fell? (estimate OK) \_\_\_\_\_
3. Within the past year did he/she have to limit activities for a day or more because of a fall?  Yes  No
4. Within the past year how many times would you say he/she caught themselves or has lost their balance? \_\_\_\_\_
5. Anything else you think we may need to know or concerns you may have?

**The following set of questions will help personalize a referral.**

- 6. Does he/she have a primary care physician?  
 Yes    No - GO TO # 9.    Don't Know - GO TO # 9.
- 7. When was the last time he/she saw their physician?  
 Within the past year    More than a year ago    Don't know
- 8. Has he/she spoken to their physician about a previous fall or about their risk of falling?  
 Yes    No    Don't Know
- 9. Does he/she take 4 or more prescription medications?  
 Yes    No    Don't Know
- 10. When was the last time he/she had their vision checked?  
 Within the past year    More than a year ago    Don't Know
- 11. Does he/she have low vision even while wearing corrective lenses?  
 Yes    No    Don't Know
- 12. Does he/she need assistance with any of the following activities (check all that apply)?  
 Bathing    Dressing    Eating    Using the toilet    Vacuuming  
 Laundry    Preparing meals    Does not need any assistance    Don't Know
- 13. Does he/she require assistance from a person or assistive device (cane, walker, wheelchair) to leave home?  
 Yes    No    Don't Know
- 14. Who is their medical insurance provider? We need to know this information in order to refer them to the appropriate home health agency (if needed). \_\_\_\_\_

**Some of our providers are funded by grants and some of the grants are geared towards helping specific populations. Please answer the following to help us identify service providers to meet your needs.**

- 15. Gender of person to receive fall prevention services:    Female    Male
- 16. Age:    64 yrs or younger    65– 69    70– 74    75–79    80–84    85 yrs or older
- 17. Race/ethnicity (check all that apply):    American Indian or Alaska Native    Asian  
 Black or African American    Native Hawaiian or Other Pacific Islander    Hispanic or Latino  
 White    Other \_\_\_\_\_
- 18. Income:  
- For a household of **one**, does he/she make below \$902 per month?    Yes    No    Not applicable    Don't know  
- For a household of **two**, does he/she make below \$1214 per month?    Yes    No    Not applicable    Don't know

**Where would you like us to send the referral information?**

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

**Preferred method of delivery (Check ONE of the options below)**

e-mail (please provide e-mail address) \_\_\_\_\_

Physical Address: Street \_\_\_\_\_ Apt /Suite/Unit# \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**For Office Use Only**

Rev. 5/2010

Date received: \_\_\_\_\_ Received by: \_\_\_\_\_

Date referral sent: \_\_\_\_\_ Referral sent by: \_\_\_\_\_