



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 Senior Source Website Fall Prevention Network Website
 Internet search Brochure Newspaper (Name) _____
 Presentation (specify location) _____ Community Event (specify) _____
 Other (specify) _____

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 Hispanic or Latino White
 Black or African American Native Hawaiian or Other Pacific Islander 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

Date received: _____ Received by: _____

Date referral sent: _____ Referral sent by: _____