

Birmingham Falls Prevention Service referral form

This form is designed to gather information about older Birmingham residents who may be at risk of having a fall.

This form can be completed by an individual, by a friend, relative or carer of an individual or by an agency or organisation supporting an individual.

A separate document called 'Guidance notes for completing the Falls Prevention Referral Form (ACF0500–Guidance)' is available if you need help to complete this form.

If this guidance document is not included with this form please contact us for a copy.

Phone: 0121 675 5171

Email: fallsprevention@birmingham.gov.uk
Web: www.birmingham.gov.uk/fallsprevention

If you are filling in this form by hand, please write in BLOCK CAPITALS

Section 1 – Personal details

To be completed by, or on behalf of, the person requesting falls prevention support.
Title: Mr, Mrs, Miss, Ms, Other (please state)
First name:
Last name:
Date of birth: Sex: please tick
Male Female

OFFICE USE ONLY

CareFirst ID:
Form number:
Date:
Helping Hand Pack given?
Yes: No:

Data Protection Act 1998

The personal information on this form is to be kept safe and is protected by law. This means that:

- we only use it for the reason given on the form;
- we only share it with people who really need to know it;
- we only keep it for as long as we have to;
- people have the right to see the information we hold about them.

See full statement on page 10.

Ethnicity: Please note this question is for research purposes only and will not affect any services you may be offered. Please tick one box only.
A. White White UK Gypsy or Irish Traveller White other
B. Mixed / multiple ethnic group White & Black Caribbean White & Black African White & Asian Any other Mixed / multiple ethnic background
C. Asian / Asian British Indian Pakistani Bangladeshi Chinese Asian other
D. Black / African / Caribbean / Black British African Black other
E. Other ethnic groups Arab Please State Other:
Address: including postcode Home phone number:
N/lobilo vala ova variable viv
Mobile phone number:
Birmingham area/ward:
Email address:
Do you have any communication needs? For example, you need information in large print or Braille, you have hearing difficulties, or need an interpreter. Yes No If 'Yes', please state which need or language
Marital status: please tick one box only
Single Married / Civil Partnership
Cohabiting Separated / divorced Widow / widower
Employment: please tick one box only Retired Employed Self employed Unemployed Carer Homemaker Training / Education Other – please state:

Home tenure: please tick one box only	
Home owner	Renting from council
Renting (Housing Association/Trust)	Renting from private landlord
Living with relatives	Other – please state:
Your doctor's details	
Name of doctor / GP:	
,	
Name of surgery:	
Address of surgery:	Phone number:
How would you like to be contacted in t	he future? Please tick all that apply.
Phone Post	Email
I would like someone else to be cont	acted on my behalf
If you would like someone other than yo	urself to be contacted on your behalf
with any information about falls prevent	
First name:	Last name:
Relationship to you:	
Llama address including pasts day	Hama phana numbari
Home address including postcode:	Home phone number:
	Mobile phone number:
	Wiesing priorite Harrister.
Email address:	
How would this person like to be kept in	formed? Please tick all that apply.
Phone Post	Email

	ails of agency			
	ou represent an organisation vidual, please provide you			s form on behalf of an
First	t name:		Last name:	
Org	anisation/agency:			
Woı	rk address including postco	ode:	Work phone nur	nber:
			Mobile phone nu	umber:
Ema	ail address:			
Sect	i on 2 – Previous fall hist	orv		
1.	How many times have y		in the last 12 mg	onths?
	Please tick one box only.			
	None	Once	9	Two to three times
	Four to six times	Seve	n times or more	
2.	Four to six times Did you have a fall over			c one box only.
2.				c one box only.
2.	Did you have a fall over	12 montl	hs ago? Please tick	c one box only.
	Did you have a fall over Yes	12 montl No nate date	hs ago? Please tick	c one box only.
	Did you have a fall over Yes What was the approxim Month: If you have never had a fall	12 montl No nate date	hs ago? Please tick of your last fall? Year: to Section 3 – 'Yo	
	Did you have a fall over Yes What was the approxim Month:	12 montl No nate date	hs ago? Please tick of your last fall? Year: to Section 3 – 'Yo	
	Did you have a fall over Yes What was the approxim Month: If you have never had a fall otherwise please continue What happened after you	No No late date of to Question	hs ago? Please tick of your last fall? Year: to Section 3 – 'Yo n 4.	ur current situation',
3.	Did you have a fall over Yes What was the approxim Month: If you have never had a fall otherwise please continue What happened after you bid you visit your G.P?	No No nate date of to Question our last fa	hs ago? Please tick of your last fall? Year: to Section 3 – 'Yo n 4.	ur current situation',
3.	Did you have a fall over Yes What was the approxim Month: If you have never had a fall otherwise please continue What happened after you	No No late date of to Question	hs ago? Please tick of your last fall? Year: to Section 3 – 'Yo n 4.	ur current situation',
3.	Did you have a fall over Yes What was the approxim Month: If you have never had a fall otherwise please continue What happened after you bid you visit your G.P?	No No nate date of to Question our last fa	hs ago? Please tick of your last fall? Year: to Section 3 – 'Yo n 4.	ur current situation',
3.	Did you have a fall over Yes What was the approxim Month: If you have never had a fall otherwise please continue What happened after you Did you visit your G.P? Yes	No No nate date of to Question our last fa	hs ago? Please tick of your last fall? Year: to Section 3 – 'Yo n 4.	ur current situation',
3.	Did you have a fall over Yes What was the approxim Month: If you have never had a fall otherwise please continue What happened after you bid you visit your G.P? Yes Did you visit a hospital?	No	hs ago? Please tick of your last fall? Year: to Section 3 – 'Yo n 4.	ur current situation',
3.	Did you have a fall over Yes What was the approxim Month: If you have never had a fall otherwise please continue What happened after you Did you visit your G.P? Yes Did you visit a hospital? Yes	No	hs ago? Please tick of your last fall? Year: to Section 3 – 'Yo n 4.	ur current situation',
3.	Did you have a fall over Yes What was the approxim Month: If you have never had a fall otherwise please continue What happened after you do you visit your G.P? Yes Did you visit a hospital? Yes Did you stay in hospital?	I please go to Question No No No No No	of your last fall? Year: to Section 3 – 'Yon 4. III? Please tick 'Yes'	ur current situation',

	Did you get any help from	adult social care (Adults and Communities)?
	Yes	No
	If 'Yes', what help did you	get?
	Did you pay for this help?	
	Yes	No
	If you answered 'Yes' to be referred to a Falls Clir	any of the above questions, would you like to nic?
	Yes	No
5.	When you last fell, were	
	Yes	No
6.		you taking four or more different medications?
	Yes	No
	Were you taking vitamin I Yes	No
7.		ou have any of the following health conditions?
/.	Please tick 'Yes' or 'No' to e	
	Deafness or severe hearing	g impairment
	Yes	No
	Blindness or severe visual	impairment
	Yes	No
	Learning disability	
	Yes	No
	Anxious or nervous when	moving around
	Yes	No
	Physical difficulty moving	around unaided
	Yes	No
	Problems with balance	
	Yes	No
	Stroke	
	Yes	No
	Dementia	
	Yes	No

	Heart condition / breathing problems (for example, coronary heart disease or chronic obstructive pulmonary disease)
	Yes No
	Diabetes
	Yes No
	Depression
	Yes No
	Other, please state:
Sect	ion 3 – Your current situation
1.	Do you currently live by yourself?
	Yes No
2.	Do you currently take four or more medications?
	Yes No
	a. If 'Yes', please state how many and what they are for.
	Number of medications being taken:
	What they are being used for:
	b. Do you currently take vitamin D?
	Yes No
3.	Do you have any of the following health conditions?
	Please tick 'Yes' or 'No'.
	Deafness or severe hearing impairment
	Yes No
	Blindness or severe visual impairment Yes No
	Learning disability Yes No
	Anxious or nervous when moving around Yes No
	Physical difficulty moving around unaided Yes No
	Yes No

Problems with balance	
Yes	No
Stroke	
Yes	No
Dementia	
Yes	No
Heart condition / breath	ing problems (CHD, COPD)
Yes	No
Diabetes	
Yes	No
Depression	
Yes	No
Other, please state:	
Other, please state:	
If there is any additional	information you would like to include about any nad, please state. For example, near misses, trips,
If there is any additional previous falls you have h	information you would like to include about any nad, please state. For example, near misses, trips,
If there is any additional previous falls you have h	information you would like to include about any nad, please state. For example, near misses, trips,
If there is any additional previous falls you have h	information you would like to include about any nad, please state. For example, near misses, trips,
If there is any additional previous falls you have h	information you would like to include about any nad, please state. For example, near misses, trips,
If there is any additional previous falls you have h	information you would like to include about any nad, please state. For example, near misses, trips,

Section 4 – Information, advice and services

advice or support depending on your needs. Please note that some of the services available may incur a charge, depending on an individual's personal circumstances. Would you like some information about preventing slips, trips and Yes No If you take more than four prescribed medicines would you like us to 2. organise a review with a Pharmacist or your GP? Yes No 3. Would you like information on how to access equipment and home modifications to assist with your independence at home? Yes Would you like us to provide details or help you to arrange an 4. appointment with an optician who can carry out an eyesight test in your home? No Yes Would you be interested in taking part in an exercise activity such as Tai Chi or other gentle exercise? Yes No Would you like to receive details about our free handyperson scheme to make your house safer? For example to supply and fit grab rails or replace and make safe, broken paving slabs. Yes No 7. Would you like advice on how to keep your home warm? Yes No 8. Would you like advice on welfare/disability benefits that you may be entitled to? No Yes Would you like us to arrange for West Midlands Fire Service to carry out 9. a free home safety check? Yes No 10. Would you like to join Libraries at home scheme? Yes No

The Birmingham Falls Prevention Service can support you to access information,

11.	Would you like informatio	n on how to use a computer or internet?
	Yes	No
12.	Social, leisure and commu	nity activities
	Do you currently take part in Yes	n any social, community or leisure activities? No
	Do you have family or friend community or leisure activity	ds who help you take part in any social, ies?
	Are you able to make your or leisure activities in your a	own arrangements to travel to social, community rea?
13.	morning and day centres.	clubs? For example luncheon club, coffee
	(go to question 14)	No (go to question 15)
14.	If Yes, which club are you	
	Please comment on the type	e of activities you currently take part in.
15.		ke part in an activity or join a club in your
		neon club, coffee morning and day centres. No
	Yes	vity or club you would like to join.
	Trease state the type of activ	vity of clab you would like to join.
16.	Are there any specific hob Please state below.	bies you would like to explore further?

17.		ion you would like to include about y activities, such as services you would king part, please state.
Sect	ion 5 – Signature	
	a Protection Statement	
	personal information provided is con-	
		1998. We will use the information you s and to provide services to which you
are (eligible. We will share your details w	th other agencies that help us in
		ningham. Please note that we have a
	utory duty to disclose personal information of crimes	nation in some instances, such as:
	vestigation or prevention of crime; otection of individuals from harm or	iniury
•	details of the way the council uses, s	
		te: www.birmingham.gov.uk/privacy
	may request a copy of your persona	l information by sending a written
•	iest to:	
	porate Information Governance Te ernance Directorate	am
	floor, Lancaster Circus	
	ensway	
	ningham B4 7AB	1427
_	0121 303 4876 and Fax: 0121 675 <i>'</i> mail: DP Contacts@birmingham.g	
	_	the information on this form to provide
serv	ices and/or information and sharing	it with others. The information I provide
		n in future studies on prevention and
	itifying people who will benefit from signature:	Date:
IVIY	Jigilatai C.	

Section 6 – Your quality of life and wellbeing. Please tick one box only for each question

Here the confidence of the control o
How do you feel about your social life?
Please use a score of 1 to $7 - with 1$ being worst and 7 being best
1 2 3 4 5 6 7
How do you feel about your leisure activities?
Please use a score of 1 to $7 - with 1$ being worst and 7 being best
1 2 3 4 5 6 7
How do you feel about your accommodation?
Please use a score of 1 to $7 - with 1$ being worst and 7 being best
1 2 3 4 5 6 7
How do you feel about your personal safety in your own home?
Please use a score of 1 to $7 - with 1$ being worst and 7 being best
1 2 3 4 5 6 7
How do you feel about your personal financial situation? Please use a score of 1 to 7 – with 1 being worst and 7 being best
1 2 3 4 5 6 7
How do you feel about your health?
How do you feel about your health? Please use a score of 1 to 7 – with 1 being worst and 7 being best
Please use a score of 1 to 7 – with 1 being worst and 7 being best 1 2 3 4 5 7
Please use a score of 1 to 7 – with 1 being worst and 7 being best 1 2 3 4 5 7 How do you feel about your present mental health?
Please use a score of 1 to 7 – with 1 being worst and 7 being best 1 2 3 4 5 7 How do you feel about your present mental health?
Please use a score of 1 to 7 – with 1 being worst and 7 being best 1 2 3 4 5 6 7 How do you feel about your present mental health? Please use a score of 1 to 7 – with 1 being worst and 7 being best 1 2 3 4 5 6 7

ACF0500 June 2013

Returning this form by post

When this form is completed please return it by post using the Freepost envelope supplied. If you do not have a Freepost envelope you can write the address below on any envelope and return it by post free of charge.

Freepost Plus RSXL-JAYT-ZRGR Falls Prevention Service PO Box 16468 Birmingham B2 2DS

Returning this form by email

If you have downloaded this form or been sent a copy by email please complete the form, save it and attach to an email.

Email: fallsprevention@birmingham.gov.uk

More information

If you need more information or help to complete this form, please contact us.

Phone: 0121 675 5171

Email: fallsprevention@birmingham.gov.uk

Web: www.birmingham.gov.uk/fallsprevention

Write to:

Falls Prevention Referral Team Birmingham City Council Adults and Communities 10 Woodcock Street Level 1, Zone 5 Birmingham B7 4BL

Any changes to this form must be agreed through a formal change control process and be signed off by the Joint Director of Public Health.