

Patient Details

Name _____
 D.o.B _____
 Home Ph _____
 Mobile Ph _____
 Address _____

 Mailing Address _____
 Email _____

Referrer Details

Name _____
 Provider Number _____
 Clinic Name _____
 Address _____

 Phone _____
 Fax _____

Health Care or Concession Card? Yes No
 Aboriginal Descent? Yes No
 Torres Strait Islander Descent? Yes No
 Culturally and Linguistically Diverse Background? Yes No

Tick the boxes below that apply to you

Are currently using a walking stick or other gait aid?	<input type="checkbox"/> yes <input type="checkbox"/> no
How many falls in last 3 months? <small>Including slip/trip, lost balance, room/head spinning, legs unsteady/gave way</small>	<input type="checkbox"/> 0-2 <input type="checkbox"/> 2-4 <input type="checkbox"/> +5
How many falls in last 12 months? <small>Slip/trip, lost balance, room/head spinning, legs unsteady/gave way</small>	<input type="checkbox"/> 0-2 <input type="checkbox"/> 2-4 <input type="checkbox"/> +5
History of collapsing and/or legs giving way?	<input type="checkbox"/> yes <input type="checkbox"/> no
History of feeling dizzy or lightheaded?	<input type="checkbox"/> yes <input type="checkbox"/> no
Fear of falling and/or low confidence?	<input type="checkbox"/> yes <input type="checkbox"/> no
Any visual impairment?	<input type="checkbox"/> yes <input type="checkbox"/> no
Any loss of sensation or feeling in one or both feet?	<input type="checkbox"/> yes <input type="checkbox"/> no
Any history of vertigo or other vestibular issue?	<input type="checkbox"/> yes <input type="checkbox"/> no

Add any extra relevant information in the box to the right	
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Signature

Date