

Put a Spring In your Step (SIS) Referral

External Referral Form

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Patient Details	Referrer Details		
Name	Name		
D.o.B	Provider Number _		
Home Ph	Clinic Name		
Mobile Ph	Address		
Address			
	Phone		
Mailing Address	Fax		
Email			
Health Care or Concession Card? Aboriginal Descent? Torres Strait Islander Descent? Culturally and Linguistically Diverse	Yes No Yes No Yes No Yes No Yes No Yes No		
Tick the boxes below that apply to you Are currently using a walking stick or other gait aid? □ yes □ no			
		□ yes □ no	
How many falls in last 3 months Including slip/trip, lost balance, room/head s		□ 0-2 □ 2-4	□ +5
How many falls in last 12 months? Slip/trip, lost balance, room/head spinning, legs unsteady/gave way		□ 0-2 □ 2-4	□ +5
History of collapsing and/or legs giving way?		□ yes □ no	
History of feeling dizzy or lightheaded?		□ yes □ no	
Fear of falling and/or low confidence?		□ yes □ no	
Any visual impairment?		yes no	
Any loss of sensation or feeling in one or both feet?		yes no	
Any history of vertigo or other vestibular issue?		yes no	
Add any extra relevant informations to the right	ion in the		
Signatura			

- 10 Hospital Street Daylesford 3460 t:03 5348 2227 f:03 5348 1447
- 22 Victoria Street
 Trentham 3458
 t: 03 5424 1602
 f: 03 5424 1851
- 89 Piper Street
 Kyneton 3444
 t: 03 5422 1298
 f: 03 5422 1307

abn: 7491 79<u>27 268</u>