REFERRAL FORM

Fall Prevention Patient Referral

PATIENT INFORMATION

Patient:	Referred to:
Sex: ☐ Male ☐ Female DOB: / /	
Address:	Address:
Phone:	Phone:
Email:	Email:
Diagnosis:	

TYPE OF REFERRAL

Type of specialist:

Exercise or fall prevention program:

Additional recommendations:

REASON FOR REFERRAL

☐ Gait or mobility problems	☐ Medication review & consultation
☐ Balance difficulties	☐ Inadequate or improper footwear
☐ Lower body weakness	☐ Foot abnormalities
☐ Postural hypotension	☐ Vision <20/40 in ☐ Right ☐ Left ☐ Both
☐ Suspected neurological condition (e.g., Parkinson's disease, dementia)	☐ Home safety evaluation led by occupational therapist

Other reason:

Other relevant information:

Referrer signature: _____ Date: _____

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

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STEADI Stopping Elderly Accidents, Deaths & Injuries