# Fall Prevention Patient Referral

## Patient Information

<table>
<thead>
<tr>
<th>Patient:</th>
<th>Referred to:</th>
</tr>
</thead>
</table>
| 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
- [ ] Balance difficulties
- [ ] Lower body weakness
- [ ] Postural hypotension
- [ ] Suspected neurological condition (e.g., Parkinson’s disease, dementia)

Other reason:  
Other relevant information:  

Referrer signature: ___________________________ Date: ___________________________

---

**U.S. Department of Health and Human Services**  
**Centers for Disease Control and Prevention**  
**STEADI: Stopping Elderly Accidents, Deaths & Injuries**  
2017