

Fall Prevention Patient Referral Form

Patient:	Referred to:
Sex: DOB:	
Address:	Address:
Phone:	Phone:
Email:	Email:
Diagnosis:	
Type of Referral	
Type of specialist (See back of form):	
Exercise or fall prevention program (See nurse for options):	
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 R L Both
Suspected neurological condition (e.g., Parkinson's disease, dementia)	Home safety evaluation
Other reason:	
Other relevant information:	
Referrer signature:	Date:



Reasons for referral	Suggested specialists
Gait or mobility problems, balance difficulties, lower body weakness	Physical therapist
Postural hypotension, medication review & consultation	Subspecialty provider
Foot abnormalities, inadequate or improper footwear	Podiatrist or pedorthist
Suspected neurological condition	Neurologist or geriatrician
Vision impairment	Ophthalmologist or optometrist
Home safety evaluation	Occupational therapist
Other	