

| Current Functional Information | | | | |
|-----------------------------------|--------------------------------------|--|--|---------------------------------|
| Mental Status | <input type="checkbox"/> Normal | <input type="checkbox"/> Impaired | MMSE | / 30 |
| Emotional | <input type="checkbox"/> Normal | <input type="checkbox"/> Depression | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Other |
| Communication | <input type="checkbox"/> Normal | <input type="checkbox"/> Impaired | | |
| Mobility | Transfers | <input type="checkbox"/> Independent | <input type="checkbox"/> Assisted | <input type="checkbox"/> Unable |
| | Walking | <input type="checkbox"/> Independent | <input type="checkbox"/> Assisted | <input type="checkbox"/> Unable |
| | <input type="checkbox"/> Aids _____ | | | |
| Balance | <input type="checkbox"/> Normal | <input type="checkbox"/> Impaired | <input type="checkbox"/> Falls # _____ | |
| Bowel / Bladder | <input type="checkbox"/> Continent | <input type="checkbox"/> Incontinent | | |
| Nutrition | Weight _____ lbs | <input type="checkbox"/> Stable | <input type="checkbox"/> Loss | <input type="checkbox"/> Gain |
| Activities of Daily Living | <input type="checkbox"/> Independent | <input type="checkbox"/> Assisted | <input type="checkbox"/> Unable | |
| Social | <input type="checkbox"/> Lives alone | <input type="checkbox"/> Lives with other: _____ | | |
| Main Social Support | <input type="checkbox"/> Family | <input type="checkbox"/> HCNS/CCNS | <input type="checkbox"/> Other | |

Patient's Family Physician has been contacted and is aware of AND agrees with referral to the Geriatric Day Hospital/Falls Clinic. *In the interest of integrated patient care, the patient's Family Physician must be notified of this referral by phone or by faxing a copy of this referral form to the family physician. Thank you for your attention to this.*

| | | | |
|---|--|---------------|--|
| Signature (<i>Physician signature is required for MSI purpose</i>) | | | |
| Name (Please Print) (<i>If trainee, please provide attending MD name</i>) | | | |
| Date | | Date Received | |

Who is Eligible to Attend Falls Clinic?

Persons who:

- * are 65 years or older
 - * have had one or more falls
- OR
- * have had mobility or balance problems
 - * agree to be assessed by the Falls Clinic staff
 - * are able to take part in an exercise program

Please note - patient must be able to attend a 2 hour session twice weekly for 6-8 weeks