REQUEST FOR CONSULTATION

GOLD COAST HOSPITAL AND HEALTH SERVICE

**FALLS AND BALANCE CLINIC**

Template for correspondence about patient with

**FALLS AND/OR BALANCE ISSUES**

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| **SEND TO**: Dr Suba Kumar  Central Intake Unit  Fax: 1300 668 536 **OR** Phone: 1300 668 936  **Secure transmission service via Medical Objects or**  **Healthlink to**  **QHEALTH,GOLD COAST HEALTH Adult Community Health Central Intake Unit** | **FROM**  **Doctors Name:**  **Practice Name:**  **Practice Address:**  **Phone:**  **Fax:**  **Email:**  **Provider Number:**  **Signature:** |

**This service is for patients who have experienced:**

* Recent, recurrent falls or near falls and/or significant balance or gait instability; Falls with significant complications (skin tears, extensive soft tissue bruising, fractures);
* Falls resulting in presentations to the GP or Emergency Department

**Please advise patients to bring all medications usually taken at home, their usual footwear and walking aids to their clinic appointments.**

Dear Dr Suba Kumar

**SECTION 1 Patient details**

**Patient Full Name:**

**DOB:**

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| **Gender:**  **Address:**  **Home Ph**:  **Mobile Ph:**  **Medicare Number\*:**  (\*Medicare ineligible patients will incur a consultation fee) | **Next of Kin/Alternative Contact:**  **Next of Kin/Alternative Contact Ph:**  **Does patient identify as Aboriginal and/or Torres Strait**  **Islander:**  **Interpreter required:**  **If yes, specify language:** |
| **SECTION 2 Reason for referral and additional clinical information** | |

What is the reason for this referral:

Please provide provisional diagnosis (if available):

Please include any symptoms and date of onset (if known):

**Paste or type relevant history, clinical examination findings and treatment to date if required**

**SECTION 3 Mandatory clinical information**

Does your patient use hearing aids:

If yes, please specify hearing aids used:

Does your patient use visual aids:

If yes, please specify visual aids used:

Does your patient use any walking aids:

If yes, please specify walking aids used:

Has your patient had any allied health input:

If yes, please specify allied health input:

Has a Team Care Arrangement been completed:

If yes, [attach GPMP/TCA](#CUSTOM)

Does the patient live alone:

If no, specify living arrangements:

**SECTION 4 Investigations**

Please indicate whether the following pre-requisite investigations have been undertaken in order for this referral to be processed and attach the results. In addition, please also attach any investigation results you consider to be relevant, including: any previous specialist or allied health reports, nerve conduction studies, EEG, EMG, Holter reports, echocardiogram reports, X/R, CT and/or MRI reports.

**FBC, lipids, E/LFT, glucose within 3 months:**

**TSH:**

**Vitamin D:**

**Vitamin B12:**

**Folate:**

**Magnesium:**

**Bone densitometry:**

**SECTION 5 Social factors and impact on the patient**

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| Consider the impact on employment/education; activities of daily life; ability to care for others; personal safety/frailty;  other factors. **Please paste or type relevant information.** |

**SECTION 6 Medical history including co-morbidities and previous surgical interventions**

**Alcohol Status/History:**

**Smoking Status/History:**

**Medical History:**

**Comorbidities:**

**Previous Procedures:**

**Allergies/Adverse Reactions:**

**Current prescribed medications:**

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| **SMOs/VMOs in this Specialist Service** |

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| Dr Suba Kumar (Senior Specialist) | Dr Pallavi Bansal | Dr Sivanajah Lliango |
| Dr Pan-Kar (Claudia) Wong |  |  |