**PATIENT DETAILS:**

|  |  |  |
| --- | --- | --- |
| **SURNAME:** | **FIRST NAME:** | **DOB:** Click here to enter a date. |
| **ADDRESS:** | | |
| **TEL NO:** | | |

**INCLUSION CRITERIA: Does the patient meet any of the following?** (Please check the relevant boxes)

|  |  |  |  |
| --- | --- | --- | --- |
| **Fear of falling** | **Feeling unstable** | **History of Falls** | **Low bone density** |

**PAST MEDICAL HISTORY:** (Please check relevant boxes)

|  |  |  |
| --- | --- | --- |
| **Heart Condition** | **Circulation condition (inc stoke)** | **Osteoporosis** |
| **Respiratory Disease** COPD  Asthma | **Long Term Condition**  MS  Parkinsons | **Other:** |
| **History of previous surgery or joint replacement** (please specify)**:** | | |
| **History of Fracture** (please specify): | | |

**BLOOD PRESSURE: /**

**CURRENT MEDICATION:** (Please attach a copy of medication)

**EXCLUSION CRITERIA FOR POSTURAL STABILITY:**

* Uncontrolled: pain, angina, BP>180/100, tachycardia >100bpm, acute systemic illness, visual or vestibular disturbances.
* Unstable angina/ acute heart failure
* Unable to maintain sitting balance , due to neurological deficit
* Impaired cognition – unable to follow simple movement instructions.

**Verbal consent given by patient to share information:** (Please check relevant box) **Yes  / No**

|  |  |
| --- | --- |
| **Form completed by:** | **Health Professional Job Title:** |
| **Email:** | **Date** Click here to enter a date. |

**If you wish to be contacted about the progress of this patient, please supply your email address above**

|  |  |
| --- | --- |
| **GP’s Contact Name:** | **Contact Number:** |
| **Name and Address of Patients Surgery:** | |

***Please send this form to the Hayley Gwillam***

**Hayley.Gwillam@bromsgroveandredditch.gov.uk**

**Redditch Borough and Bromsgrove District Councils, Sports Development, The Town Hall, Walter Stranz Square, Alcester Road, Redditch, B98 8AH**

***For more information please contact the Hayley Gwillam on 01527 881404***