

FallScope Referral Form

Participant:	Referred to:
DOB:	
Address:	Address:
Phone:	Phone:
Email:	Email:

CDC STEADI Falls Risk Questions

<input type="checkbox"/> Have you fallen in the past year?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Do you feel unsteady when standing or walking?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Do you worry about falling?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

If the participant answers “yes” to any of the above questions, he or she is at risk of falling.

Other

Other reason for referral:

Other relevant information:

Referred by:

Date:

- This person is aware that a falls prevention leader will be in contact.

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Adapted from the Center for Disease Control and Prevention's STEADI Toolkit.