Address

Telephone

Email

**Volunteer Community Exercise Referral Form**

Community Exercise Volunteers can provide 8 weekly home visits once the patient has been discharged from hospital. This support will enable them to support the physiotherapy prescribed exercises at home.

**This service is open to residents of Kingston Borough and for any patient who:**

* Is 65 years old or over
* Had had a fall in the last 12mths, at risk of falls, or is worried about falling
* Unable to access exercise classes or is housebound therefore at risk of loneliness and social isolation

**Physical outcomes criteria:**

* Timed up and go – must be less than 40sec with a walking aid or independently
* 180 Turn- 10 steps or less with a walking aid or independently
* STS 60 secs- no minimum criteria

**Exclusion criteria:**

* Patients with serious pathologies or who are not medically stable
* Patients admitted with Covid
* Patients who need manual assistance walking
* Patients who have significant cognitive impairment and are unable to engage in assessment or follow instructions.

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| **Patient Contact Details** | | | | | |
| First and last names |  | | | | |
| Patient Address |  | | | | |
| MRN/ NHS number |  | | Gender | Male  Female | |
| Date of birth |  | | Age |  | |
| Telephone number  (Home) |  | | Telephone number (Mobile) |  | |
| NOK name and contact number |  | | | | |
| Has the patient consented to the referral and home visits? Yes  No | | | | | |
| Has the patient been referred to other services? Yes  No  If yes, which ones; | | | | | |
| **Initial Assessment:** | | | | | |
| Had a Fall in the last 12 months (Y/N) Number of falls:  Fear of Falling (Y/N) Score 0-10:  180 degree turn (number of steps):  STS- 60 sec test (number of STS): TUAG (time taken in seconds):  Any other relevant medical or social history for volunteers to be made aware of: (e.g living arrangements, hearing or visual impairments)  Any safety alerts to be made aware of: (e.g. safeguarding issues/allergies/other residents/pets) | | | | | |
| **Physiotherapy Prescribed Exercises (Please ensure patient has been discharged with a copy of home exercise programme)**  **Please list any exclusions to the exercise programme provided:** | | | | | |
|  | | | | | |
| **Referrer Name** | **Designation:** | **Contact number:** | | | **Date:** |
|  |  |  | | |  |
| **For Volunteer  (Office use only)** | **Volunteer allocated to:** | **Volunteer contact number:** | | | **Date allocated:** |
|  |  | | |  |