

# Shasta County Public Health Fall Prevention Program CLIENT REFERRAL FORM

This form is to be used by the Fire Department to refer older adults who are at risk for falls and have accessed the 911 system, to the Shasta County Public Health (SCPH) Fall Prevention Program operated by Home Health Care Management, Inc. (HHCM).

ALL INFORMATION IS CONFIDENTIAL

Date of Referral: \_\_\_\_\_

**CLIENT IDENTIFICATION**     Repeat Referral

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone No: \_\_\_\_\_

Date of Birth/Age: \_\_\_\_\_

Sex of Client:    Male     Female

M.D. name if available \_\_\_\_\_

Phone: \_\_\_\_\_

Transport?     Yes     No

Hospital     Mercy Med. Center  
                   Shasta Regional Med. Center  
                   Mayers Memorial

## **CLIENT RESIDENCE**

Does the client live alone?     Yes     No

If not, how many in household? \_\_\_\_\_

Relationship to client? \_\_\_\_\_

Emergency Contact Name/Telephone: \_\_\_\_\_

Condition of Home \_\_\_\_\_

**Home Health Care Management, Inc**  
**Megan McComas, R.N.**  
**1620 E. Cypress Avenue, Suite 1**  
**Redding, CA 96002-1356**  
**Voice: 800-400-0727**  
**FAX REFERRALS TO: (530) 224-7186**

Name:    **Redding Fire Department**

Incident No: \_\_\_\_\_

Referring Officer: \_\_\_\_\_

Station Number: \_\_\_\_\_

Reason for Referral: \_\_\_\_\_

Mechanical Fall     Ladder or Step Stool

Standing     Sitting

Trip Hazard     Medication

Blackout

Speaks English:    Well     Poorly     None

Primary language \_\_\_\_\_

**REMINDER: YOU MUST REPORT CASES OF SUSPECTED ABUSE TO ADULT PROTECTIVE SERVICES (APS)**

**(530) 225-5798**

I authorize the Fire Department to contact the SCPH Fall Prevention Program operated by HHCM to refer assistance.

\_\_\_\_\_  
*Patient Signature*