

Telephone Triage Questionnaire – Community Therapy

Patient Name:	URN: Date:
Contact Number:	Alerts:
Seen by OT/PT in the last year? If so please review outcomes / discuss with the therapist	
Do you live alone? Support network? House/flat/bungalow/other Community Alarm? POC?	
How are you managing at home? What are your main issues? Is there anything you are finding difficult?	
Mobility: Indoor Outdoor Aids in situ i.e walking aid, wheelchair, rails? Do you feel safe?	
Falls: Fallen in the last 12 months? Were you injured? Details of fall: Blacked out Dizzy Palpitations: if yes refer to GP with consent Were you able to get up from the fall? Near miss falls in last 12 months? Feel at risk of falling?	
Internal External Stairs: Steps: Aids in situ i.e rails?	
Transfers: Bed Chair Toilet Bath/shower Aids in situ i.e bed rail, pillow lift, chair raise, rise/recliner, raised toilet seat, rails, bath board, shower seat, perch stool etc?	
Personal ADL's Washing Dressing Eating/drinking Pressure sore/care Aids in situ i.e. perchstool, trolley, long handle sponge, shoe horn, easy reach grabber?	
Domestic ADL's: Shopping Cooking	

Cleaning Laundry	
Are there any other issues or concerns?	
Can you attend WARC or do you need a Home Visit?	
Do you want to be put on the cancellation list? Can you attend an apt at short notice? Are there any days that need to be avoided?	
Priority: Complexity: Speciality : Physio/OT Allocation: if seen a PT twice please allocate to others in the team Home visit / gym Transport required Phone follow up Trak comments	

Completed by:

For and on behalf of Health and Community Services