PLEASE PRINT

Name:_____
LAST FIRST

Date of Birth:_____/_____/19_____

MRN:_____

STANFORD HOSPITAL AND CLINICS
STANFORD, CALIFORNIA, CA 94305

ADMINISTRATIVE •
FAREWELL TO FALLS REFERRAL FORM

Today's Date	Time	
Participant Phone Number ( )	Sex ❑ Male ❑ Female	Translator Needed: ❑ Yes ❑ No If Yes, Language:
Participant Address	City	State Zip
Description of Fall		
Has participant ever been a patient of Stanford Hospital and Clinics? ❑ Yes ❑ No		

PARTICIPANT AUTHORIZATION

I, _____ grant permission for my name, address, phone number and age to be shared with Stanford Hospital and Clinic's Trauma Service for referral to their fall prevention program for seniors, Farewell to Falls Program.

_____ _____ _____
Name Signature Date

Referred By (Name)	Referring Agency ❑ SHC ED ❑ Fire/Paramedic:_____ Agency ❑ Primary Care Physician (PCP) ❑ Palo Alto Medical Foundation Urgent Care ❑ Other:_____	Phone Number ( )
Stanford ED: Place referral forms in Trauma Box **All others: Fax form to 650-725-2359**		