Falls and Balance Clinic Manual

Introduction

Welcome to Kingston Falls and Balance Clinic. Patients with falls and balance problems attend the clinic for one-off assessment. Initially they have an initial home assessment which includes cognition, drugs safety and transfers at home and a history. They are then seen by the doctor and a physiotherapist. A variety of interventions are recommended, including therapy usually at a CRC and a home programme if possible, investigations and modifications are recommended. A follow up appointments is usually scheduled 4 months after initial assessment, to assess effectiveness of interventions.

Learning Objectives - General

1. Identify the multi-factorial causes of why patients fall
2. Learn all aspects of the multi-disciplinary approach to falls
3. Specifically identify medical risk factors for falls and modify these risks accordingly
4. To assess a patient with a vestibular disturbance and to identify the relevant cause
5. To manage fracture prevention
6. To understand the role of cognition and depression in falls
7. To understand role of vision in falls
8. To understand role of impaired BP regulation in falls
9. To understand role and causes of syncope in falls
10. To understand the role of therapy in falls

Learning Objectives – Specific Skills

1. Take a history for falls, precipitating factors, vestibular history
2. Examination of gait
3. Examination of balance
4. Examination for delayed postural hypotension
5. Precise examination for peripheral neuropathy
6. Examination for Parkinson’s disease and Parkinson’s Plus
7. Examination of vision – including MET and depth perception
8. Vestibular examination
9. Interpret a 24 hour BP monitor and adjust anti-hypertensive drugs accordingly
10. Interpret a Mini – Best assessment
11. Interpret vestibular function tests
12. Calculate a calcium intake and prescribe correct Vitamin D replacement

Contents

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10. Professional Organizations, Conferences and Seminars

In the morning clinic there is a very strict doctor to physiotherapy ratio because the patients usually have to see both. Most appointments are for one hour. In the afternoon there is a separate vestibular clinic run by the physiotherapists.

Following the initial assessment the patients may be reviewed separately by the physios to see if they are managing their exercise programmes. Occasionally patients need medical only reviews. Otherwise they are routinely reviewed by both physio and medical staff after 4 months. This is to allow them to have CRC based therapy in the meantime. However this may not necessarily have happened for various reasons including waiting times, non-compliance and most commonly difficulty with transport.

Admin Support
Appointments for patients are often made weeks in advance and family members may have taken time off work to be here. Please ring the administrative staff on 9265 1411 if you are
unable to attend a planned session so that alternative arrangements can be made for the patients if necessary.

Please advise FABC in advance of any days when you cannot attend e.g. annual leave, conferences.

The histories are in red pockets and there should be a timetable set out. These are on top of the filing cabinet. If you can’t find the red pocket the physios often have them.

Any filing goes into the filing uncompleted FABC tray on top of the filing cabinets.

If you need help during the clinic ring or go and see the go to person who sits at the angled desk in the corner of reception.

The following team members assess each patient:

**Occupational Therapist**

The OT sees the patient at home for an initial assessment see (pdf). A history is taken which is recorded on the falls history sheet. (see pdf) This is to try to prevent duplication of history taking. However it is difficult to record onto this sheet as patients usually don’t give a history in such an ordered fashion.

A medication assessment is done to record what the patient is actually taking and how they are taking it. An assessment of transfers is done within the home environment. A calcium intake, optometry assessment for depth perception and contrast sensitivity is done and it is noted when the last optometry review occurred. A social history, fluid and caffeine intake are taken. A MMSE is performed, FES-1 which is a fear of falling scale, a CLOX test to assess executive dysfunction is done along with a GDS and questions for the frailty scale.

**Geriatrician**

This is my suggested approach to how you approach seeing a clinic patient. There is a form (see pdf) to record the examination and help direct your thinking. It lives in the drop registrar folder in the top most drawer closest to the door in reception. If there isn’t one there ask for it to be printed from the G drive assessment form folder.

Read the health summary if there is one. If there are references to relevant specialists or investigations which aren’t there, ask admin to ring the GP to get them. Read the falls history which the OT has taken and then look at the falls efficacy scale. Note or circle what you think are important flags eg anti-hypertensives, collapse admissions, difficulty walking on uneven ground, dizzy looking up, MMSE, falling at night, doing 2 things at once etc. Then do the history and examination – see below.
**Physiotherapist**

The assessment tool we use is the miniBEST (see article and record sheet-pdf). This addresses each component of dynamic balance. These are stability during quiet stance, postural reactions to external disturbances, anticipated adjustments when needed eg lifting object, and dynamic balance during gait. The aim being that the therapist can then determine what therapy is needed. It also includes the CTSIB which assesses the somato-sensory system. One of the difficulties with the original validation paper for the CTSIB is that it looked at asymptomatic versus subjects with vestibular impairment performance on foam, but did not include subjects with peripheral neuropathy. Hence the physios tend to think that difficulties on foam are a vestibular issue, but also foam significantly decreases sensory input, so will worsen in peripheral neuropathies too.

Attached in pdf is an analysis of functional tasks and tests written by Prue Morgan a previous physio in the Clinic. It identifies what the underlying causation may be and the normal ranges and normative data.

The physios will also perform rigorous strength testing, particularly those who also work in the gait lab and in research. We are fortunate to have 2 physios one with vestibular and orthopaedic subspecialisation and the other with neurological and movement disorders subspecialisation, so it is often worth asking for additional input when you are in doubt.

Therapy consist of a mix of home programmes and CRC based therapy. There is often a long wait for CRC. If the patient is being referred to private rehabilitation, they need a doctor’s letter, and there is a proforma for this. The patients may be reviewed in a few weeks by the therapist, to monitor progress and increase compliance.

If there isn’t time to do a formal vestibular examination a separate appointment can be made.

**History**

It is essential to get a witness report of the event surrounding the fall if at all possible because:

- The patient may not remember loss of consciousness– 30%
- The witness can give information about the length of time of blackout and whether there was associated tonic clonic movements, colour, eye movements, recovery time
- The patient may have cognitive impairment
- Research shows that even cognitively intact older people living in the community do not remember the falls after 3 months

**Ask**

Tell me about your fall –often you will get an unclear picture about what happened.
Below is a list of questions to ask and factors to consider:

Where were they? – Indoor fallers have a much higher risk than outdoors because they are falling in a less challenging environment.

What time? – At night think about continence lighting and obstacles in the room

What were they doing at the time – dual task, risk taking behaviour

Do they fall backwards, fall backwards - central balance, PSP classically fall backward, but a lot of patients with frontal gait disorder do too.

Do they fall forwards – often when they are doing things and reach out of their base of support –eg pulling out weeds, hanging out the washing

Were there any obstacles involved – stepping off gutters- poor depth perception, irregular path – may not have scanned environment, poor foot clearance

Do they go bang or have severe facial injuries – cardiac causes

L.O.C – remember 30% have amnesia for this

What was the lighting like? – Poor light, visual dependence

Do they have a gait aid and were they using it?

What footwear were they wearing?

Injuries?

Were they able to get up by themselves – if not high risk further falls, try to teach, personal alarm if cognitively able

- If they have had syncope or if you suspect syncope, it is very important to ask about recovery time. If it is immediate think arrhythmia. If they feel washed out for several hours then consider a vasovagal episode

- Do they dislike walking on uneven ground or slippery surfaces = peripheral neuropathy

- Obstacles, steps, gutters – foot clearance, depth perception, attention

- Stairs –most people fall down. Also ask what they were doing on the stairs e.g carrying things. If they fall up think about contrast sensitivity and foot clearance

- Accompanying symptoms – palpitations, feeling as if going to faint, presyncopal symptoms eg nausea, hot, sweaty

History of near falls – very important

Often feel unsteady all the time, Overbalance but can regain balance, particularly on turning or dual task
**Medical History**

Diabetes or fasting glucose >5.5 – always think about peripheral neuropathy

Hypertension- there is an association between systolic hypertension and postural hypotension

Operations – did they have delirium? – cognitive impairment

Cardiac failure – is it systolic or diastolic, can their diuretics be reduced, are they on optimal therapy? If they have diastolic dysfunction this likely to be due to long standing hypertension

A.F – only arrhythmia associated with increased falls risk – note a fall is not syncope

Continence: urinary urge incontinence has been shown to be a risk factor for falls in community dwelling and institutionalised older people.

Nocturia: it is common and associated with falls. Nocturia can be a problem when the lighting is poor and the person is not fully awake. Also overnight hypertension causes a diuresis.

Dizziness (see vestibular history). Important to understand what the patient thinks of as dizziness. Then you need to differentiate causes, postural hypotension, vestibular, sometimes it is simply unsteadiness.

Hearing and tinnitus: sense of aural fullness, episodes and duration,

Osteoporosis risk factors and investigations: DEXA, Ca intake, Vit D status, previous #

Review medication list

Determine activity level and fear of falling – see OT home assessment and FES-1

Depression – check GDS

**Examination**

1. Walk the patient: make sure the patient’s legs are clearly visible.
   
   Observe: posture, base of support, arm movements, stride length, unsteadiness and gait variability
   
   a. Ask the patient to walk normally for a ten meters and then
   
   b. Ask the patient to walk while turning his head from left to right and observe for unsteadiness and dizziness and ask if this makes them dizzy
c. Walking while dual tasking. Ask the patient to walk while performing serial 3’s (standardised) or serial 2’s (much easier for older people) or days of the week backwards, and if they can’t do this, name the grandchildren

If they are more unsteady on head turns than dual task they may have BPPV, vestibular dysfunction or cervicogenic dizziness

d. Ask the patient to stop suddenly – overrun think PD

e. Ask patient to walk quickly

f. Ask them to turn around – look for no. of steps (normal=3), unsteadiness, turning out of base of support, en bloc (think about Cx spine), festination, watch what they do with their gait aid.

g. Watch them to sit down – what do they do with gait aid, safety techniques do they flop back – frontal DWMI or PSP.

Gait abnormalities: - see Bas Bloem Classification

- Prefrontal lobe(apraxic): feet appear glued to floor when erect, but move more easily when the patient is supine – cycling on the bed

- PD: the patient has difficulty getting going, the gait is shuffling and there is retropulsion

- Hemiplegic gait: steps are shorter, slower and the gait is less smooth because the affected leg swings out in the arc

- Cerebellar disease: a wide-base unsteady gait

- Sensory ataxia: patient obviously watching the ground and their feet rather than looking ahead

- Normal pressure hydrocephalus: wide-base ataxic gait

- Antalgic gait: asymmetrical because the patient puts their weight on the side with the painful joint for as short time as possible

- Proximal myopathy: secondary to steroids and osteomalacia, waddling gait

- “Scissoring “ gait: OA of the hips severely reduces the range of flexion at the pelvis during walking

- Foot drop: high-stepping, foot-slapping gait, e.g. secondary to a common peroneal nerve palsy
h. Balance

a. Feet together Eyes open Feet together Eyes closed

b. Do Modified Sharpened Rhomberg, and then sharpened Rhomberg and if they can do this

c. Heel-to-toe walking

d. Walk on the toes (an S1 lesion will make it difficult or impossible)

e. Walk on the heels (an L4 or L5 lesion causing footdrop will make this difficult or impossible)

f. Pastors test

The examiner stood directly behind each subject and delivered the instructions: "I am going to tap you off balance, and I won't let you fall." Information about the direction and timing of the perturbation are not given. The examiner then delivers a brief and quick tug to the subject's shoulders in a posterior direction with sufficient force to destabilize them

Postural reactions in response to the external perturbation were scored by the examiner using the 5-clinical rating scale described by Pastor et al:

<table>
<thead>
<tr>
<th></th>
<th>Subject stays upright without taking a step</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>Subject takes one step backward but remains steady.</td>
</tr>
<tr>
<td>3</td>
<td>Subject takes more than one step backward but remains steady.</td>
</tr>
<tr>
<td>4</td>
<td>Subject takes one or more steps backward, followed by the need to be caught</td>
</tr>
<tr>
<td>5</td>
<td>Subject falls backward without attempting to step.</td>
</tr>
</tbody>
</table>

1. Examination on the bed. This is an integrated examination incorporating general and neurological features. Pay particular attention not to miss peripheral neuropathy, muscle weakness, abnormal tone or reflexes, loss of proprioception. Is there evidence of PD, frontal signs?

a. Parietal drift

b. Finger fine movements

c. Palmar escape reflexes
d. Check the pulse rate and rhythm.

e. Arm strength

f. Reflexes in arm

g. Pout reflex

h. JVP and carotid bruits

i. Heart and lungs

2. Lower limbs

a. Look for arthritis and check its severity and acuity, peripheral oedema, venous excema, venous pooling, hair loss, pulses if you suspect intermittent claudication, leg length discrepancy and foot abnormalities

b. Check range of movement at hips and knees and ankles

c. Neurological examination

<table>
<thead>
<tr>
<th>Grade 5</th>
<th>Normal muscle strength, this is assigned when the examiner is unable to break the patient’s holding position. The patient must be able to complete a full ROM and maintain the end point of range against maximal resistance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Grade 4</td>
<td>The patient must be able to complete a full range of motion against gravity and can tolerate strong resistance. The muscle ‘gives’ to some extent with maximum resistance at the end of range.</td>
</tr>
<tr>
<td>Grade 3</td>
<td>The person can complete a full range of the position of the head in relation to gravity. Additional resistance causes the muscle to ‘break’. This grade represents the functional threshold for each movement tested, ie the muscle can achieve the minimum task of moving the part</td>
</tr>
<tr>
<td>Grade 2</td>
<td>The patient can complete a full range of motion in a position that decrease the effect of gravity – often a horizontal plane of movement.</td>
</tr>
<tr>
<td>Grade 1</td>
<td>The examiner can detect visually or by palpation some activity in the muscle with movement</td>
</tr>
</tbody>
</table>
Grade 0 | The muscle is completely quiet on palpation and with visual inspection

Sensory examination requires a tuning fork and filaments. The filaments are in the back drop file in the drawer. Do not steal as we cannot replace them!! Do vibration first and ask – is it as strong as on your chest? Keep going up until you find this level

The change in proprioception which can be perceived in a normal system is minute. Just close your eyes and move the distal phalanx of your finger a minute amount and you will perceive it. You can move the toe a little and say if it is up or down. If they can perceive this then ask them to say yes when they first feel you move the joint. This should be almost instantaneous. Keep going up the leg to find at which joint they can perceive minimal movement.

The filaments come in 3 different strengths. Start with the 10g filament. Test on the inner aspect of their arm, it should bend mildly. Then start at their feet and ask them to say yes if the feeling gets stronger. This gives you a sensory level. If you don’t find one and suspect the patient has a peripheral neuropathy, use the 75g filament, more as light touch because of frail skin. Record which filament you used and at what level the sensation changes.

3. Cerebellar examination.

4. Specific examination for L-S BP and HR – use a manual sphygmomanometer. The drop is significant if it is more than 20mmHg systolic and accompanied by symptoms.
   a. Do after the patient has been lying for at least 5 min – this allows for compensatory mechanism to have resolved and to mimic overnight lying.
   b. Stand immediately (well as immediately as possible in our patients)
   c. Take BP and HR immediate, 1 min, 3min, 5 min.
   d. If the BP is falling, continue to check but remember taking BPs every 15s will also drop the BP (decreased venous return)

5. Hearing and ears _ Rinne, Webers, inspect drum

6. Vision – poor contrast sensitivity, poor visual acuity, impaired depth perception and self-reported poor vision are strong risk factors for falls. Ask the patient if they have been assessed by the optometrist in the last 12 months.
Results of Melbourne Edge test (edge-contrast sensitivity test) will be provided to you by occupational therapist. Loss of edge-contrast sensitivity predispose older people to trip over obstacles at home as well as outdoor hazards, such as steps, kerbs and pavement cracks. Score of less than 18/24 indicates visual impairment.

Depth discrimination is grossly tested with Louie the fly and 3D glasses. You can more sensitively test it using the circles which will grade it.

Multifocal glasses use is prevalent in older people, and their use is strongly associated with falls, especially on stairs. Ask the patient if they wear multifocal glasses and if they do – suggest changing them to 2 pairs for long distance and reading.

Perform visual field test-refer to optometrist or ophthalmologist if any abnormalities detected.

Check eye movements - ?PSP

7. Vestibular examination – see separate section

8. Assess cognition (results of MMSE will be provided to you). Ask about signs of depression and perform short GDS, if not already done and if >3 continue with full GDS. The CLOX test which is a test of executive function is also done. A lot of our patients have executive difficulties, unmasked when you give them a sheaf of request slips and they are bewildered even though you have just explained the requests to them. It is often also identified by the OT, when she sees the patient and notes the disorganisation.

Putting it all together

There is a specific form to record the findings and help formulate diagnoses and management plans (see pdf).

There are 2 ways of formulating the letter and also your thinking. One is to determine the actual diagnosis eg peripheral neuropathy or the other is to think of how it influences balance e.g The patient has decreased static balance due to a peripheral neuropathy. You are welcome to use either. I prefer to use a diagnostic rather than mechanistic approach because I am concerned that GPs don’t understand balance and that even the difference between static and dynamic balance is unfamiliar to them.

Included is an analysis of assessment findings and primary contributing factors for impaired balance also written by the physiotherapist Prue Morgan. However the more recent MiniBest is more focussed on the systems involved and particularly on challenges in dynamic balance eg obstacles.
Investigations:

This can be done in 2 ways, either by asking the GP to order them, or do it yourself. It is preferable to order them yourself as they are far more likely to be done. Always copy the GP into the results. Beware Monash never send MRI reports, so you have to have a system to check them. I put a sticker on a sheet of paper in my drop folder to keep track of them.

1. **Routine** – ie. all should have: FBE, ESR, B12, RCF, vit D, U&E, Ca P, LFT, fasting glucose, CK, urine M&C, Th spine XR for 20% decrease in vertebral height and ECG

2. **24 hr BP monitors.** Very useful. Use to assess for labile blood pressure, overnight hypertension, post prandial hypotension, episodes of hypotension, and overall control. In particular look to see if there is heart rate variability, if this is present then autonomic neuropathy is unlikely. You can then change BP medications accordingly. However they are expensive. The cheapest is Monash heart at $60. However, they only take ½ hourly BPs and won’t routinely give you the graphs, you have to ring and ask for them. There is no Medicare rebate.

3. **Holter monitors** are only useful in about 18% of patients with collapse. Use if you suspect tachy or bradyarrhythmias

5. **Echocardiograms.** Use if long Hx of hypertension, may have diastolic dysfunction or outflow tract obstruction. Murmurs, particularly suspect AS or systolic heart failure.

5. **Head CT.** Use if you suspect they have a frontal gait disorder, vascular mild cognitive impairment or strokes.

6. **MR Brain.** Use if you are looking for posterior fossa or brainstem pathology. Other than the public hospitals only Frankston MIA will bulk bill for MRs ordered by a specialist.

7. **CT L-S or Cx spine.** If you are looking for lumbar canal stenosis, nerve root impingement at one site. If you think they may have disease at both sites, do MR spine because of the radiation dose.

8. **Vestibular function tests.** These can now only be done at the Alfred, RVEEH and at Knox. Use if you suspect a vestibular lesion, particularly hypofunction, and you haven’t been able to detect it. You have to write a letter to the Oto-Neurology Service at the Alfred to have these done. RVEEH have a form and these are available in the drawer in reception. They are the only service that perform static posturography. The patients generally dislike going to the RVEEH because of the distance. At Knox there is a private clinic with a cost to the patient of about $40. Forms are in the filing cabinet draw.

9. **Autonomic function tests.** These are available at Monash Neurology. We rarely perform them except if you want a limited tilt table study when you suspect they might have postural hypotension and haven’t been able to prove it.

10. **Glucose Tolerance Test.** If the patient has a peripheral neuropathy and has a family history of diabetes, or a glucose of $\geq 5.5$ it is advisable to do this. This is because hyperglycaemia in itself can cause a peripheral neuropathy in the absence of a formal diagnosis of diabetes.
11. **Additional Tests for peripheral neuropathy.** TSH, SPEP

12. **Bone Mineral Density.** Do if they don’t have a history of low trauma fracture or don’t have 20% decrease in vertebral height on Th Spine XR.

**Recommendations other than investigations**

1. **Impaired blood pressure regulation which is significant or if the patient has syncope**

Refer them to Dr Sue Corcoran at the Syncope Clinic, Caulfield Hospital, Kooyong Rd, Caulfield. You will need to send a referral letter and to order a 24 hour blood pressure monitor, ECG, Holter monitor and echocardiogram and have Dr Corcoran copied into the result.

2. **Nocturia**

Restrict caffeine intake to a maximum of 2 cups per day before noon and don’t have any fluids after 6pm. Consider referral to continence clinic

3. **Postural hypotension**

First of all consider the patient’s volume state. Most elderly people don’t drink enough fluid. If the JVP is not visible, they are normotensive and don’t have heart failure ask them to drink 1200 - 1500ml a day, recording this by adding to a jug and equal volume of what they drink.

If they are hypotensive, and volume deplete and not on an antihypertensive consider adding salt to the diet.

If they are posturally hypotensive and on medication, decrease the diuretic first, or cease the diuretic component of dual therapy.

Systolic hypertension is associated with postural hypotension and treating the systolic hypertension decreases the falls risk, but not the postural hypotension. It is advisable to do a 24 hour blood pressure monitor to see if they are hypertensive overnight. If this is the case, use a short acting antihypertensive such as captopril at night, or a nitrate patch which can be removed in the morning. Sometimes it is worth considering splitting the antihypertensive timing to b.d. so you can increase the night time dose if there is significant nocturnal hypertension. Alternatively if there are 2 antihypertensives you can give one in the morning and the other at night, so they are not both becoming active around the same time.

If they are symptomatically hypotensive and don’t respond to the above you can consider fludrocortisone. This simply increases the lying and standing BP, but doesn’t change the amount of drop. Midodrine can also be used, but this drug is not available in Australia but may be accessed through SAS. Pyridostigmine has also been used. Phenyl ephedrine and psuedoephidrine have also been used, and in combination with fludrocortisone.

Non pharmacological interventions include cross legged stance when standing, squatting, leaning forwards, flexing ankles before standing, tensing muscles for 30 sec when standing, elevated head of bed overnight, recumbent exercise eg rowing machine or swimming, abdominal binder to increase
venous return from the splanchnic circulation, 2 cups of brewed coffee in the morning and none thereafter and drinking 2 cups of water.

4. **Difficult vestibular patients**, particularly if concerned about somatoform vertigo or vestibular migraine.

Refer either to John Waterston, Cabrini Medical Centre or Mark Paine. Public Clinics at the Alfred and Eye and Ear Hospital

5. **Movement disorder issues eg ?PSP**

Refer to our Movement Disorder Clinic.

6. **Arthritis**

Consider hydrotherapy, topical voltaren gel, glucosamine, steroid injection, surgical review and Pain Clinic.

7. **Pain**

If this is difficult to manage or requires Allied Health specialist input, refer to Pain Clinic

9. **Bone Health**

   a. If unknown osteoporosis status order Th-L umbar spine XR for 20% decrease in vertebral height

   b. If this is normal ask the GP to order a BMD if they are over 70.

   c. Aim to treat vitamin D to level >75. Here is a proforma.

I would recommend 1/2/3/4/5 vitamin D tablets daily for 6 weeks and that you recheck the level with the corrected calcium at this time.

At 6 weeks the vitamin D dose may need to be adjusted according to the level. A rough guide is < 20 – 5 vitamin D tablets, < 30 – 4 vitamin D tablets, 30 -50 3 vitamin D tablets, 50-70 2 vitamin D tablets, above this 1 vitamin D tablets.

Then repeat the level with a corrected calcium after a further 6 weeks later and adjust accordingly.

Please delay starting any anti-osteoporotic agent until the vitamin D level is > 75.

   d. **Calcium**

There is considerable controversy about supplemental calcium. The patient needs to have an adequate calcium intake while taking vitamin D. My practice is to calculate the calcium intake and then add in additional calcium to achieve an intake of 1200mg daily. Usually patients require supplemental calcium to reach this level. A quick guide is 250mg = 1 serve calcium = 250ml Glass milk/2slicescheese/tub of yoghurt. There is a calcium intake chart for your reference on the web site under resources.
e. Osteoporotic agents

If considering a bisphosphonate, please check the patient’s teeth, and recommend a dental referral. Most our patients have poor dentition. Also, remember that the patient qualifies for alendronate or zolendronic acid if they have been taking prednisolone 7.5 mg or greater, for >3 months and have a BMD t-score of less than -1.

10. Mild Cognitive Impairment and or Executive Dysfunction

You are likely to consider these diagnoses after having dual task walking and the score and patient behaviour on the dual task component of the the mini Best. If they are relatively young refer these patients to CDAMS clinic for a formal diagnosis and order a head CT or MR Brain if there is little evidence of DWMI on CT and you have a high clinical suspicion. If they are very elderly and there is evidence of DWMI on CT, and no other cognitive issues it is often easier for the patients that you make a clinical diagnosis and note this in the letter to the GP.

11. Medication compliance and multiple drugs

Consider a Home Medication Review – Item 900 for GP

12. Lumbar Canal Stenosis

Most doctors consider that this presents purely with pain. However, it can present at which ever level is involved with compression of which ever nerve. The working definition is buttock or lower extremity pain, which improves with sitting, forward flexion or a recumbent position. If it is present in the lumbar canal it may also occur in the cervical canal so the best investigation to do is a MR spine. The initial treatment is physiotherapy, even though decompression laminectomy has a better outcome, it has a complication rate.

Letter - logistics

You need to specify that you saw the patient in the Falls and Balance Clinic at the Kingston Centre because the letters are now printed on generic Southern Health letterhead.

The clinics now use Ozescibe. Here is how to obtain a user name and password.

- Open Monash Health Intranet page.
- Select Non Clinical Services.
- Select Ambulatory and Community Care (ACC)
- Open Medical Transcription Services.
- Select Dictation Application Form.
- Complete relevant details.

When completing form it will ask for Department – type in “Specialist Clinics

Many trainees and some consultants prefer to type their own letters. If you do this just dictate the doctors and the patient’s details and then you can copy and paste your own letter into Ozescibe. The letters from Ozescibe are supposed to be sent to the doctor and scanned medical record. This is sometimes not the case, a problem on which we are working.
**Letter - Content**

The most important thing to remember is you are aiming for GP compliance with your recommendations. We also ask the patient to attend with their letter to encourage GP compliance. So, put the diagnoses first and then the recommendations. The recommendations should also include the home modifications and gait aid recommendations. This is usually the first page, and this probably only what the GP will read. If you want the GP to do something, say so e.g. please can you order this and put it in bold.

Those with bad handwriting are encouraged to write more detailed letters. This is because when someone else reviews the patient they may want to know a particular detail, or whether an issue was considered or not.

Only include what is relevant, so all the abnormal signs, and results. However, if you are surprised by something being normal, e.g. diabetic with no signs of peripheral neuropathy who reports difficulty walking on uneven ground, then you should comment on this.

If you are fortunate enough to have had the physio see the patient first, and have the miniBest and TUGs etc it is important to put them in. Usually however, you don’t have them and can’t add them in with Ozescribe.

If you want e.g. the cardiologist to review the patient and get them off their diuretics, write to the cardiologist directly.

Please copy the letter to all doctors involved and any referring physio who won’t be able to access scanned medical records.

If the patient usually presents to Sandringham ED but comes to our clinic because of council boundaries, then copy a letter to Sandringham medical records. Maybe someone might read it when they re-present to ED!

I have included 2 different letter formats as examples.

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**The Team Meeting**

We aim to hold this at 11.30 but usually it is later. This is a good opportunity to listen to the differing presentations we see, the diagnoses and to discuss diagnostic dilemmas. Please feel free to bring your lunch as this is usually the only time we get to eat. Try to keep strictly to topic to minimise the length of the meeting.
The purpose is to write a letter to the patient outlining the causes of their falls and our recommendations. We try to limit the diagnoses number to 4, as we don’t want to overwhelm the patients. There are frequently more, but we don’t include them. List them in priority order. There is no limit to the number of recommendations. We ask the patient to take the letter to the doctor to increase GP compliance.

If the OT has logged in as herself there is access to the Care Plan Phrases. These can be auto-populated into a letter to save typing time. There is a copy of these attached.

**Abnormal Results**

Write to the GP with your recommendations. There are proforma letters for abnormal BP monitors and abnormal Vitamin D results. These are saved on the MONARC web site.

**The Review Appointment**

These can often be very messy. The best way to prevent this is by reading the list of recommendations before you see the patient and checking if the results are on scanned medical record. If not give the admin ‘go to person’ the list of what is outstanding for them to chase up.

If the patient had postural hypotension, ask them to lie down when they come into the consulting room in order to have 5 min lying before standing them. Explain the reason to the patient, as they usually expect to sit and talk before any examination.

First thing to ask is have they had any more falls. Then ask if they have been to therapy. Often they haven’t or only went for one or 2 sessions, so don’t expect any dramatic improvement. Go through the list of recommendations one by one, including home modifications.

Then do the postural BPs if you need to do this.

If you want the patient to follow up on anything get the Pain Clinic instructions carbon copy medical record form and write them down. This will improve compliance. I know it takes a bit of time, but they won’t remember what you tell them. Even 21 year olds only remember one thing the doctor tells them.

We usually discharge them from the clinic at this time.