GERIATRICIAN REFERRAL FORM

Dr Kate Gregorevic

MBBS(Hons), FRACP

PATIENT'S FULL NAME: ______________________________

ADDRESS: ______________________________

SUBURB: ______________________________

POSTCODE: __ __ __ __

TELEPHONE NUMBER: ______________ (Home) ______________ (Mobile)

DATE OF BIRTH: ______________

MEDICARE NUMBER: ___/___/___/___/___/___/___/___/___/___/___

No. on Card: ____ Expiry Date: ___/_____

NEXT OF KIN FULL NAME: ______________________________

CONTACT NUMBER: ______________________________

REFERRING DOCTOR: ______________________________

PROVIDER NUMBER: ______________________________

REASON FOR COMPREHENSIVE GERIATRIC ASSESSMENT:

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SPECIFIC CONCERN (please tick as many as required):

- Functional decline/ frailty ☐
- Cognitive assessment: ☐
- Falls and balance: ☐
- Incontinence: ☐
- Medication review: ☐
- Other (please specify): ______________________________

Please include (if applicable)

- Health summary
- Aged Care Assessment
- Over 75 health assessment

SIGNATURE: ______________________ **DATE:** ___________

Please email this form to admin@elderhealthaustralia.com or fax to (03) 8528-5003

Please remind your patient to bring his/her list of medications to the assessment