Bayside Health Peninsula

# GERIATRIC MEDICINE CLINIC REFERRAL

**Fax this referral to ACCESS: 03 9125 5862**

UR NUMBER .....

SURNAME .....

GIVEN NAMES .....

DATE OF BIRTH .....

Please fill in if no Patient Label available

App.16/6/26 Print Code:18445

PHF5536699

**All referrals must meet GMC criteria and need to include patient demographics, reason for referral and clinical details, medical history and current list of medications, and copies of all relevant investigation results and correspondence**

**Incomplete referrals will not be accepted and will result in a delay to access of care.**

Date: ..... Consent to referral: Yes ☐ No ☐

No consent, provide details: .....

## PATIENT DEMOGRAPHICS

Name: ..... DOB: .....

Address: .....

Contact number: ..... Consent to SMS? ☐ Yes ☐ No

Email: .....

Alternative Contact Details *(Consent to contact)*? ☐ Yes ☐ No Is this the preferred contact? ☐ Yes ☐ No

Name: ..... Relationship: ..... Phone: .....

Medicare number: ..... ..... General Practitioner Name: .....

GP Clinic Name and Number: .....

Aboriginal / Torres Straight Islander: Yes ☐ No ☐ Language spoken ..... Interpreter required: Yes ☐ No ☐

## REASON FOR REFERRAL

☐ Clinical assessment ☐ Diagnosis ☐ Inform treatment plan ☐ Specialist advice ☐ Request for specific tests or treatments

***Please note:*** *GMC does not provide ongoing intervention or management and patients will be discharged to the care of their primary physician and referred to appropriate community services*.

## CLINICAL DETAILS

*Please tick and provide relevant details for the presenting problem, including current management to date and the impact of the problem on the patient.*

☐ **Comprehensive Geriatric Assessment.**

☐ Complex/multiple medical conditions ☐ Frailty ☐ Functional decline ☐ Polypharmacy ☐ Mood ☐ Carer stress ☐ Pain

☐ Safety / Psychosocial concerns ☐ Cognition changes / Falls ***(please complete separate sections below)***

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☐ **Cognitive assessment.** Please provide history of cognition / memory changes *(or existing diagnosis details)* including symptoms, duration of decline, safety concerns and relevant assessments/investigations

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*We encourage the following investigations to be completed prior to the referral to avoid delay in assessment, diagnosis and treatment: CT Brain within 12 months, Blood tests within 3 months (FBE, CRP, EUC, Se calcium / magnesium / phosphate, LFTs, TFT, Se B12 and folate), 12-lead ECG (if cholinesterase inhibitors are indicated), MMSE / MOCA.*



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Peninsula Health

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PHF5536699g

☐ **Falls**

Number of falls / near falls past 12/12: .....

Injuries (fractures or head strikes): .....

Please provide further details: .....

.....

Current or recent allied health involvement for falls? ☐ Yes ☐ No
*If no, please consider additional ACCESS referral to Falls Prevention Service.* .....

## MEDICAL HISTORY AND MEDICATIONS

*Please attach past medical history and / or current medication list to the referral. Alternatively, please provide details below:*

Past Medical History: .....

.....

.....

Medications: .....

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Additional relevant details including medication management and allergies: .....

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## ADDITIONAL INFORMATION

**Relevant psychosocial history:** .....

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**Community supports:** .....

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**Safety / risks** *(including barriers to access service)*: .....

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**Legal:**

Has the patient appointed Enduring Powers of Attorney? ☐ Yes ☐ No EPOA Name(s): .....

Has the patient completed an Advanced Care Directive? ☐ Yes ☐ No
*Please ensure Bayside Health (Peninsula Group) have an up-to-date copy of any EPOA, ACD or planning documents.*

## REFERRER DETAILS *(Please note that the Geriatric Medicine Clinic requires a Medical Practitioners referral).*

Print name: ..... Signature: ..... Provider No: .....

Designation*: ..... Role/Ward/Service: .....

Date: ..... Contact details: .....

*Are you a Bayside Health consultant geriatrician or making a referral in consultation with / on behalf of a Bayside Health (Peninsula) consultant geriatrician? ☐ Yes ☐ No If yes, name of consultant: .....