

### GERIATRIC MEDICINE CLINIC REFERRAL

Attn: Head of Unit: **Dr Anjali Khushu**  
Fax this referral to ACCESS: 03 9125 5862  
email: [ascottreferrals@phcn.vic.gov.au](mailto:ascottreferrals@phcn.vic.gov.au)

UR NUMBER .....  
SURNAME .....  
GIVEN NAMES .....  
DATE OF BIRTH .....  
Please fill in if no Patient Label available App.12/12/2023 Print Code:18445

#### General Eligibility Criteria:

Please refer to the GMC Referral and triage CPG for specific criteria

- Over 65 years old (or under 65 with geriatric medical condition/s)
- Requires medical assessment and management plan for complex and/or multiple medical conditions and/or psychosocial issues
- Symptoms of advanced undiagnosed dementia
- Polypharmacy

#### Referrals not accepted for:

- Requests for capacity assessment
- Cognitive assessment following delirium within 3 months of delirium episode (unless additional medical management is required)
- Requests for urgent appointments or inpatient admission
- Requests for delayed appointments (eg 6 month review)

All referrals 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.

Consent to referral: Yes  No

Date: ..... Please provide details if no consent obtained: .....

#### PATIENT DEMOGRAPHICS

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

Address: .....

Contact number: ..... Email: .....

Alternative Contact Name and Number: .....

Preferred Contact Name / Method: .....

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

GP Clinic Name and Number: .....

Aboriginal / Torres Strait Islander: Yes  No  Transport required: Yes  No  Unsure

Language spoken: ..... Interpreter required: Yes  No

Medical treatment decision maker, support person or carer details (if applicable): .....

#### CLINICAL DETAILS AND REASON FOR REFERRAL

Please tick and provide relevant details for the presenting problem and the impact of the problem on the patient. (Please note: GMC does not provide ongoing intervention or management and patients will be discharged into the care of their primary physician and referred to appropriate community services).

##### PRESENTING PROBLEM(S)

**Comprehensive Geriatric Assessment** (please outline all relevant clinical details for assessment) .....

**Cognitive assessment**

Duration of noted cognitive decline\*: .....

Known dementia diagnosis: (subtype/who made diagnosis/when): .....

Safety concerns

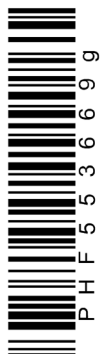
Behavioural and psychological symptoms of dementia (BPSD)

Please provide details: .....

**Falls**

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

\*Referrals for cognitive assessment within 3 months following a delirium episode will not be accepted. Please request GP to refer to CDAMS or GMC 3-12/12 following delirium episode if cognitive assessment is still required. Referrals accepted where additional medical management is required (eg. falls).



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

▶ Current or recent allied health involvement for falls? Yes  No

Please provide details: .....

Carer stress / Psychosocial concerns .....

Functional decline .....

Polypharmacy .....

Mood (please treat and exclude as cause of cognitive decline prior to referral if referral is for cognitive assessment) .....

Other .....

Reason for referral (eg. diagnosis, clinical assessment, inform treatment plan, specialist advice, specific tests or treatments. Please note: GMC does not provide ongoing management or intervention)

Current management to date (eg. current/past treatment and response, existing community supports, barriers to accessing services)

**INVESTIGATIONS** Please complete and attach results of all relevant investigations.

If referral is for cognitive assessment, we request the following investigations are completed prior to referral:

- CT brain (within one year of referral)
- Blood tests (within three months of referral)
  - FBE  CRP  EUC  Se calcium / magnesium / phosphate  LFTs  TFT  Se B12 and folate
- 12-lead ECG (if cholinesterase inhibitors are indicated)
- MMSE score (if available): ..... / 30 OR MOCA score (if available): ..... / 30

**MEDICAL HISTORY** (Please attach current medical history to referral)

Additional relevant details: .....

**MEDICATIONS** (Please attach current medication list to referral)

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

**ADDITIONAL INFORMATION**

Does the patient have a Home Care Package (HCP)? Yes  No  Level: .....

Please provide case manager details if available (name/provider/contact number): .....

Is the patient on a waitlist for a HCP or awaiting an ACAS assessment? Yes  No

Do you have concerns regarding safety (physical/financial/psychological)? Yes  No  Details: .....

Has the patient appointed Enduring Powers of Attorney? Yes  No

Please provide details including if EPOA has been enacted: .....

Is the patient under active care of a geriatrician or recently been under the care of a geriatrician? Yes  No

Please provide geriatrician details and reason for additional geriatrician referral: .....

**Referrer Details** (Please note that the Geriatric Medicine Clinic requires a Medical Practitioners referral).

Signature: ..... Print Name: ..... Provider Number: .....

Date: ..... Contact Details: .....