Peninsula Health

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

UR NUMBER .....

SURNAME .....

GIVEN NAMES .....

DATE OF BIRTH .....
Please fill in if no Patient Label available

App.12/12/2023 Print Code:18445

PHF553669g

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 Straight 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: .....

.....

**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).*

☐ **Falls**

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

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MR/553669

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PHF5536699

► 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)*

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

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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: .....

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.....

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: .....

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

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

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