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| **Title of Form:** | **Comprehensive Geriatric Assessment Referral Form** |

**Referral date:** Click here to enter text

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| **GP Details** | | |
| First Name: (Dr) Click here to enter text | Surname: Click here to enter text | |
| GP Provider No: Click here to enter text | | |
| Clinic Address: Click here to enter text | | |
| Suburb: Click here to enter text | | Postcode: Click here to enter text |
| Ph: Click here to enter text | | Fax: Click here to enter text |
| Email: Click here to enter text | | |

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| **Geriatrician Services** | |
| Comprehensive Geriatric Assessment ***(compulsory please tick)*** | |
| ***Other Services***: | |
| Pharmacology review | Management of BPSDs |
| Cognitive assessment | Advanced Care planning |
| Comorbidities requiring specialist input | |

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| **General Medical Information for Referral:**  Click here to enter text |

Please attach: Medical history Medication list Recent blood tests

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| **Signature**: | **Date**: Enter date |

**FAX TO: (03) 9300 3283**