Acacia-Fiori Geriatrics

## REASON FOR REFERRAL

| **Comprehensive Geriatric Assessment for:** | **Date of referral:** |
|---|---|
| ❑ Cognitive issues<br>❑ Frailty and related issues (e.g.: Falls)<br>❑ Functional Decline<br>❑ Multiple morbidities and/ or Polypharmacy<br>❑ Pre-operative assessment | |

## PATIENT DETAILS

| | | |
|---|---|---|
| Surname:<br><br>Given Name(s): | DOB: | Phone: (Home)<br><br>Mobile: (Mobile) |
| Aboriginal/TSI: | Gender: | Address: |
| Medicare no: | Health Fund:<br><br>Number: | DVA: |

## GP DETAILS

| | |
|---|---|
| Name: | Contact No: |

## SUBSTITUTE DECISION MAKER/PERSON RESPONSIBLE (IF APPLICABLE)

| | | |
|---|---|---|
| Name: | Relationship: | Contact No: |