LJM Medical
Geriatric Medicine

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Referral Form for Dr Lynette Jones

Patient Information

Patient name
Patient DOB
Address
Medicare no.
DVA Y/N - if yes, DVA no
NOK name & contact number

Referral Type (please tick all appropriate)

☐ Comprehensive geriatric assessment (required comprehensive evaluation of multiple comorbidities which may include social aspects of 60 minutes duration)

☐ Focused problem review (mbs item 132)

☐ Capacity Assessment – these are considered on a case by case basis. Please liaise directly as more specific information will be needed.

Area Of Concern (particularly relevant for 132)

☐ Memory assessment

-Duration of decline?

-Please attach or advise of site of any relevant radiology

☐ Behavioural and psychological symptoms of dementia (BPSD) management

☐ Mobility

☐ Falls/ orthostatic hypotension (Falls per last 12 months? _____)

☐ medication review

☐ Frailty & functional decline

☐ Multiple comorbidities optimisation

☐Other: _____

Please attach the below to referral - not complete without reason, signature and date

☐Current medications list

☐Past Medical History

☐Behavioural History

Reason for referral:

Referrer Name:

Referrer Provider No.:

Practice Name:

Practice Contact Details:

Signature and Date