Level 2, 1 Southbank Boulevard, Southbank Vic 3006
Telephone: **03 9982 4419** Fax: **03 8676 4901**

Geriatrician - Referral Form

Patient Name:

Referring Physician Name:

Date of Birth:

Practice Address:

Address:

(Stamp)

Phone:

Contact Number:

Fax:

Clinical Details / Provisional Diagnosis: ______________________________

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Assessment required: (Please tick the appropriate box/boxes.)

- ☐ Comprehensive Geriatric Assessment
- ☐ Memory Assessment
- ☐ Acute Medical illness
- ☐ Heart Failure
- ☐ End of Life Care/Palliative Care
- ☐ Pain management
- ☐ Falls and Balance
- ☐ Continence issues
- ☐ Medication review
- ☐ wound management
- ☐ Other ………………………………………....

Signature of referring Physician.	***Date:***

Please fax this form to 03 8676 4901 or ring 03 9982 4419 to make an appointment.
(Please note: all consultations will be bulk billed)

This referral is not valid unless signed by the referring Physician

THANK YOU FOR YOUR REFERRAL

Office use only:
Appointment Date:
Time:
Initial: