MELBOURNE GERIATRICIANS GROUP

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Telephone: **03 9790 9925** Fax: **03 8676 4901** Email: **admin@melbgerigroup.com.au**

Geriatrician - Referral Form

Patient Name:

Date of Birth:

Address:

Medicare:

Contact Number:

Referring Physician Name:

Practice Address:

P: (03)

F: (03)

Email:

Clinical Details / Provisional Diagnosis:

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
☒ Follow up review in 3-6 months

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

Please fax this form to 03 8676 4901 or ring 03 9790 9925 to make an appointment.

This referral is not valid unless signed by the referring Physician

THANK YOU FOR YOUR REFERRAL

Office use only:
Appointment Date:
Time: Initial: