MELBOURNE GERIATRICIANS GROUP

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Level 14, Suite 1413-1415, 1 Queens Road, Melbourne, VIC 3004.
Telephone: **03 9790 9925** Fax: **03 8676 4901**

Geriatrician - Referral Form

Patient Name:

Date of Birth:

Address:

Medicare No:

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.
(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: