

Alfred Sandringham Caulfield

Unit:.....

REFERRAL TO GERIATRIC EVALUATION AND MANAGEMENT (GEM) AT HOME

UR:

Family Name

Given Names

Date of Birth

Gender: Male Female

Patient Details

Family Name	Given Name/s
Title <input type="checkbox"/> Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Ms <input type="checkbox"/> Miss <input type="checkbox"/> _____	Preferred Name
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Indigenous <input type="checkbox"/> Yes <input type="checkbox"/> No
Address	
Ph Mob	Ph Other
Contact Person Name	Ph
Relationship to patient	
Interpreter required <input type="checkbox"/> Yes <input type="checkbox"/> No	Preferred language
Who to contact to arrange first visit	<input type="checkbox"/> Patient <input type="checkbox"/> Contact Person

Reason for referral

Identified risk/s for home visits Yes No
If yes, list:

Please attach the following information

Current medication list	Allergies
Social / Family History	Medical History
Investigations / Test Results	

Referring Dr Name	
Referring Dr Signature	
Referring Dr Address	Date / /

Fax Referral to: GEM at Home, Caulfield Hospital
260 Kooyong Road, Caulfield, 3162
Fax: 9076 4825 Ph: 0439 526 869

