

Aged Care Consultation request, Southern Aged Care Evaluation, Rehabilitation Service SACERS

Please *FAX* or *MAIL* completed form to: **FAX** No.: 08 9431 2993

Mail Dept of Community & Geriatric Medicine S.A.C.E.R.S., PO Box 480, Fremantle 6959

Consultation request

Unit No:	Date:
Name:	M/S/W/D:
Address:	D.O.B.:
Lives with:	Telephone:
Presently at:	Telephone:
Next of Kin:	Relation:
Address:	Telephone:
Ref. Doctor:	Address:
Telephone:	Email:

Reason for referral:

Please tick as appropriate

(Prof D Bruce / Dr R Clarnette / Dr A McCutcheon / Dr M Wilson / Dr J Kitchin / Dr E Johnston / Dr N Martin)

- | | |
|-------------------------------------|----------------------------|
| 1.Medical opinion | 6.Home aids |
| 2.Residential care | 7.Dementia assessment |
| 3.Respite care | 8.In-home respite |
| 4.Community Aged Care Package. | 9.Day therapy |
| 5.Community Support Services. | 10.Continence |

Presenting problems:

Please tick as appropriate

Medical


1. ...Dementia
2. ...CVA/Stroke...
3. ...Parkinson's Disease
4. ...Other neurological
5. ...Arthritis and related
6.Heart disease
7.Fractures
8.Amputee
9.Respiratory disease
10.Cancer

Functional

1. ... Confusion
2. ...Poor mobility
3. ...Incontinence
4. ...ADL inability
5.Disorientation
6.Poor vision
7.Poor hearing
8. ...Falls


Social

1. Lack of support
2. ... Social isolation
3. ...Lack of services
4. ... Despondency inertia
5. ...Recently bereaved
6. ...Carer stress
7. ... Behavioural problems
8. ...Relationship problems

Issued	Apr 2004	Compiled by	Community and Geriatric Medicine Director Fremantle / Julie Skevington GP Liaison
Revisions	2005, 2006, Feb&Nov 2008, July 2009	Endorsed by	Community and Geriatric Medicine Director Fremantle
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11.Psychiatric illness

12 Other (specify)

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Relevant medical history

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Current medications

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Doctor's signature: *Date:*.....

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