**Central Adelaide Local Health Network**

**Multi-Disciplinary Community Geriatric Service (MCGS)**

Referral Form

*MCGS is a community based acute response team providing comprehensive geriatric assessment and short-term case management for vulnerable older persons across CALHN.*

***Eligibility for service requires a Multi-D approach.***

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| **FAX completed form to (08) 8222 1480 or Email:** **Health.calhnmcgs@sa.gov.au** |
| **Date:** Click here to enter a date. **MRN:** Click here to enter text. |
| **Client Details** |
| Title: [ ]  Mr [ ]  Mrs [ ]  Miss [ ]  Ms [ ]  Other | Name: Click here to enter text.  |
| Marital Status: [ ]  Single [ ]  Married [ ]  Widowed [ ]  De Facto [ ]  Divorced / Separated  |
| DOB: Click here to enter a date.  | Aboriginal/Torres Strait Islander (50+): [ ]  Yes [ ]  No |
| Address: Click here to enter text.  | Accommodation Setting (e.g. Own Home, Renting, SAHT):Click here to enter text. |
| Phone No: Click here to enter text.  |  Client Lives: [ ]  Alone [ ]  With Partner [ ]  With Family [ ]  Other |
| Country of Birth: Click here to enter text. | Language: Click here to enter text.  |
| Interpreter Required: [ ]  Yes [ ]  No  | Advanced Care Directive: [ ]  Yes [ ]  No [ ]  Unknown  |
| **Other Details** |
| NOK/Other Contact Person: Click here to enter text.  | Relationship: Click here to enter text.  |
| Phone No: Click here to enter text.  | Does contact person hold EPOA? [ ]  Yes [ ]  No [ ]  Unknown |
| **GP Details** | **Referrer Details (if not GP)** |
| Name: Click here to enter text.  | Name: Click here to enter text. |
| Practice Name: Click here to enter text.  | Title/Designation: Click here to enter text.  |
| Address: Click here to enter text.  | Organisation: Click here to enter text. |
| Phone: Click here to enter text.  | Phone: Click here to enter text.  |
| Fax: Click here to enter text. | Fax: Click here to enter text.  |
| ***Is client aware of the referral* [ ]  Yes [ ]  No [ ]  Unknown** |
| **REASON FOR REFERRAL (please tick all that apply)** |
| [ ]  No formal cognitive diagnosis[ ]  Limited or no informal support[ ]  No formal services[ ]  Resistant to support services[ ]  Complex social situation[ ]  Suspicion of elder abuse | [ ]  Risk to self or others[ ]  BPSD[ ]  Frequent presenter to the hospital system[ ]  Failure to attend OPD[ ]  No EPOA or ACD[ ]  Falls or reduced mobility |
| **COMMENTS: (please indicate urgency / imminent risks or attach further medical information)**Click here to enter text.*If you wish to discuss further prior to completion please phone:(08) 8222 1429* |
| **MCGS Administration Only:** |
| **Referral Accepted:** [ ]  Yes [ ]  No **Priority Status:** [ ]  Priority 1[ ]  Priority 2 Waitlist [ ]   |

*Privacy disclosure: Information contained in this referral form may be private and also may be the subject of legal professional privilege or public interest.If you are not the intended receipent, any use, disclosure or copying of this document is unauthorised under the Health Care Act 2008 and may attract a fine of up to $10,000. If you have received this document in error, please contact (08) 8222 1429.*