**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**](mailto: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.*