Government of **Western Australia**
Department of **Health**
Fremantle Hospital and Health Service

Community and Geriatric GP Handbook

Print Form

Contact Phone: 9431 2673

Community and Geriatric Medicine Consultation Request

*** Required**

Please send **completed form**
Fax: 08 9431 2993 **or**
Mail: Dept of Community & Geriatric Medicine.,
PO Box 480, Fremantle 6959

*** Date of Referral**			
URN			
*** Medicare Number**		*** Reference Number**	*** Expiry Date**
*** Patient Name:**		Date of Birth	
Patient Address:			
Patient Phone/s:		Patient Email	
Interpreter		Language:	

Preferred contact: patient or NOK ◯ Patient ◯ NOK

Does the client give permission for NOK to be contacted for ACAT? ◯ Yes ◯ No

* Next of Kin/ informant name:		NOK Relation:	
NOK Address:		* NOK Phone/s:	

If person is under 65 consider Disabiliity Service Commission protocol Under 65? ◯ Yes ◯ No

If the person requires communiy aids or equipment refer to OT CAEP GP Referral Kit

◯ **Urgent**

Moss Street Medical/Allied Health

Moss Street Referrals Fax Directly to **9319 8655**

Reason for referral: Indicate below

- ☐ Parkinson's Review
- ☐ Memory Assessment
- ☐ Balance Mobility Falls
- ☐ General Medical
- ☐ Continence Review
- ☐ Physiotherapy
- ☐ Neuro-occupational Therapy
- ☐ Speech Therapy
- ☐ Clinical Psychology
- ☐ Dietitian

Other Reason

ACAT/Community

- ☐ Home Care Packages
- ☐ Residential Respite
- ☐ Residential Care
- ☐ Carer Support

Community Geriatric Review Reason

Referral Reason

Contact Phone:
9431 2673

* Required

* Patient Name:		Date of Birth	

Relevant medical history
(attach relevant information/summary if you need extra space)

Current medications (attach relevant information/summary if you need extra space)

* Referrer's Name:

Referrer's address:

* Referrer's Phone/s:

* Referrer's signature:

* Date: