**Geriatric Consultation Initial Consult Note**Primary Service:   
Attending Requesting Consult:   
Geriatrics Attending:   
Primary Care Physician: Phone No.:  
  
**Reason for Consultation:**   
  
**HPI**

**ROS:**   
//allergies none  
//meds-home:   
//meds-inpatient:

**PMH:**

**SH:**

See also Geriatric Assessment below.  
EtOH:

Smoking:   
Drugs:   
  
Language: Country of Origin:

Level of education/Literacy:   
Occupation: (before retiring)  
Lives with: Lives where: (type of housing, ?renting, steps/stairs)

Family/Children/Social Support:  
 **PE:**Vitals://vitals\_  
  
Ht: \_ Wt: \_ BMI: \_  
Gen:  
(\_) Temporal wasting  
HEENT:  
Neck:  
Pulm:  
Cardiac:  
Abd:  
GU/Rectal:  
MSK:  
Skin:  
Neuro:  
Mental Status:  
Orthostatic blood pressure: \_  
Gait: \_  
Balance: \_  
Neuromuscular: (\_) Cogwheeling (\_)Rigidity (\_) Tremor NONE

**LABS & STUDIES:**//labs-fishbone\_  
//LABLiverFunctionPanel\_  
//LABUrinalysis\_  
//PVRthisvisit\_  
  
//XR Chest \_  
  
  
**GERIATRIC ASSESSMENT:**Primary Care Physician:\_ Tel/Fax:\_  
Insurance: (\_) Medicare (\_)Medi-Cal (\_)Other  
  
Hospital Patient Safety:  
Delirium: Confusion Assessment Method: \_/5 (Positive Screen >= 4/5)  
Cognitive: Mini-Cog\_ (Positive Screen 0-2), or AD8 Interview\_ (Positive Screen >= 2); MoCA= ; RUDAS=  
Age & Weight Adjusted GFR (Cockcroft-Gault):   
Age-related Medication Issues:   
Incontinence: (\_)Yes (\_)No  
Skin Evaluation: (\_)Yes (\_) No Pressure Ulcer(s)  
History of Falls (see below): (\_)Yes (\_) No   
  
Mobility/Falls:   
Vision Problems:   
Hearing Evaluation: Right Left  
Assistive Device:  
Fear of Falling: (\_)Yes (\_) No  
Fallen in past year: (\_)Yes, Circumstance:\_  
  
Function:  
Basic Activities of Daily Living (ADLs) \_/6 Needs help with:\_  
Instrumental Activities of Daily Living (IADLs) \_/8 Needs help with: \_  
Medication Management : (\_) Self (\_) Other \_  
Life Expectancy (ePrognosis.ucsf.edu): \_  
  
Psychosocial & Advance Care Planning:  
Mood: PHQ-2 \_ (Positive Screen >=1)  
PHQ-9 \_ (1-4 min depression; 10-14 moderate depression; 20-27 severe depression)  
Medical Decisions: (\_) Self (\_) Other \_  
Spokesperson/Relationship: \_ Contact # \_  
Caregiver(s): \_ Contact # \_  
Medical Durable Power of Attorney: (\_) Yes \_  
Advance Directive: (\_)  
Advance Care Planning Form Updated in ORCHID: (\_) Yes  
Preferences: \_  
(\_) POLST  
(\_) DNR/DNI  
  
**IMPRESSION: ( Your one-liner)  
Assessment and Plan: (Write and discuss all medical problems for trauma/surgical pts)**

**Geriatric Syndromes/Problems:**  
  
#. eConsult to the Geriatrics Navigator for Community Services  
  
**SUMMARY OF RECOMMENDATIONS: (keep brief and at the most 5 recs)**1.

**2.**

**3.**

**4.**

**5.**  
Thank you for allowing us to participate in this patient’s care. Please call us at p0840 with any questions or comments.

For urgent issues after 8 pm to 8 am call 310-501-1325