**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