Phone Joyce McSwan for further information on **0412 327 795**

Forward completed Referral via **Medical Objects** (preferred) to:

Name: **Joyce McSwan**

Provider Number: **JM4226000Q0**

or Fax: **07 3539 9801**

**DATE:**

**PATIENT DETAILS**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Patient Name:** | | **DOB:** | | **Gender: M / F** |
| **Address:** | | **Email:** | | |
| **Daytime contact number: Home:** | **Work:** | | **Mobile:** | |

**Patient presentation**

|  |  |  |
| --- | --- | --- |
| Clinical History: |  |  |
|  | | |

**PAST HISTORY**

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| --- |
| Has the patient previously attended a falls prevention or frailty program/clinic? YES/NO  If yes, specify where and when: |

|  |  |
| --- | --- |
| **The patient has met ALL the following criteria to be eligible for the program (please tick):**   * The patient is > 65 years old (Older Persons) or > 55 years old (Aboriginal & Torres Strait Islander) * The patient has scored >1 in the FRAIL scale risk assessment (please see the FRAIL scale risk assessment on page 2 of this referral) * The patient is not a palliative care patient * The patient does not currently reside in a Residential Aged Care Facility * The patient requires improved self-management strategies and skills to optimise ongoing care * The patient is able to give voluntary, informed consent for the ongoing collection of audit data. | **REFERRING GP/ORGANISATION DETAILS**  *Please stamp/insert details:*  GP Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **REFERRING ALLIED HEALTH PROFESSIONAL DETAILS (if this applies)** \*\*A GP Sign off is mandatory for this referral to be accepted\*\*  *Please stamp/insert details:*  AHP Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**On the receipt of this referral, the patient will be contacted with details of the Gold Coast Primary Health Network’s Frailty Care in the Community, Healthy Ageing Program to be reviewed with an initial service assessment. Our Service Assessments will be held at our office at Corporate House, Varsity Lakes. The group-based Frailty Care in the Community Program will be held at various North and South community centres on the Gold Coast. Patients will be allocated accordingly to suit their individual needs. Please provide for your patient the “Patient Information Sheet” for their further information. Patients can also call us directly to enquire further on: 0412 327 795**

This Frailty Care in the Community, Healthy Ageing Program is supported by funding from Gold Coast Primary Health Network through the Australian Government’s PHN Program. GCPHN is collecting your personal information for the purpose of assisting its activities and functions in the primary health care sector. Your contact details may be used to forward information and notifications from GCPHN. In some circumstances we may provide your information to our funding agency (Dept of Health) or to service providers that enter into legal contracts with us which are bound by confidentiality. There is no legal requirement for you to provide your personal information, however if you chose not to disclose your personal information this may exclude you from our services and programs. We do not routinely disclose information overseas. For further information on how we manage your personal information see our website <https://gcphn.org.au/privacy-policy/>

**FRAIL SCALE RISK ASSESSMENT**

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Questions** | **Scoring** | **Results** |
| **F**atigue | How much of the time during the past 4 weeks did you feel tired?  A = All or most of the time  B = Some, a little or none of the time | A = 1  B = 0 |  |
| **R**esistance | In the last 4 weeks, by yourself and not using aids, do you have any difficulty walking up 10 steps without resting? | Yes = 1  No = 0 |  |
| **A**mbulation | In the last 4 weeks, by yourself and not using aids, do you have any difficulty walking  300 metres OR one block? | Yes = 1  No = 0 |  |
| **I**llness | Does the patient have the following conditions?   * Hypertension * Diabetes * Cancer (not a minor skin   cancer)   * Chronic lung disease * Heart attack * Congestive heart failure   □ Angina  □ Asthma   * Arthritis * Kidney disease | 0-4 answers = 0  5-11 answers = 1 |  |
| **L**oss of weight | Have you lost more than 5kg or 5% of body weight in the past year? | Yes = 1  No = 0 |  |
| **TOTAL SCORE** | | |  |
| **Scoring: Robust = 0 Pre-frail = 1-2 Frail = >3** | | | |

You can also use the Frail Scale Risk Assessment calculator: [www.painwise.com.au/frail-scale](http://www.painwise.com.au/frail-scale)