**Referral Form**

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**Vitality Passport Program**

Please send to secure fax number (02) 6033 5233

Date of Referral: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient Details**

First Name­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Surname\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gender: M/F ATSI: Yes/No

Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mobile Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current GP:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Practice:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referred by:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Height:

Weight:

Calf circumference:

Edmonton Frail Scale Scores:

|  | Score: \_\_\_/17 |
| --- | --- |
| Frailty domain | Item | 0 point | 1 point | 2 points |
| Cognition | Please imagine that this pre-drawn circle is a clock. I would like you to place the numbers in the correct positions then place the hands to indicate a time of ‘ten after eleven’  | No errors | Minor spacing errors | Other errors |
| General health status | In the past year, how many times have you been admitted to a hospital? | 0 | 1–2 | ≥2 |
|  | In general, how would you describe your health? | ‘Excellent’, ‘Very good’, ‘Good’ | ‘Fair’ | ‘Poor’ |
| Functional independence | With how many of the following activities do you require help? (meal preparation, shopping, transportation, telephone, housekeeping, laundry, managing money, taking medications)  | 0–1 | 2–4 | 5–8 |
| Social support | When you need help, can you count on someone who is willing and able to meet your needs? | Always | Sometimes | Never |
| Medication use | Do you use five or more different prescription medications on a regular basis? | No | Yes |  |
|  | At times, do you forget to take your prescription medications? | No | Yes |  |
| Nutrition | Have you recently lost weight such that your clothing has become looser? | No | Yes |  |
| Mood | Do you often feel sad or depressed? | No | Yes |  |
| Continence | Do you have a problem with losing control of urine when you don’t want to? | No | Yes |  |
| Functional performance | I would like you to sit in this chair with your back and arms resting. Then, when I say ‘GO’, please stand up and walk at a safe and comfortable pace to the mark on the floor (approximately 3 m away), return to the chair and sit down’  | 0–10 s | 11–20 s | One of >20 s patient unwilling, or requires assistance |
| Totals | Final score is the sum of column totals |  |  |  |

Relevant Medical History: