**Consult intake” *cheat sheet”***

**Please ask the referring practitioner all these questions:**

1. Patient Name ( last 4 SSN)
2. DOA:
3. Team Contact Info (name/team and extension/pager/vocera)
4. Reason for consultation ( could be more than one)
5. Is there a Health Care Proxy/Guardian/NOK( Next Of Kin), DPOA( Durable Power of Attorney)? And if yes**, name and contact info:**
6. Does the patient have previous LST (check CPRS “Postings” - R upper corner in CPRS main view), Advanced Directive ( MOLST, POLST, living will, etc.)?
7. Was the patient/family informed about this referral?
8. Level of information given to patient/family until now:
9. Brief description of this admission until today ( please see reverse, too):
* Prognosis, as stated by the team
* Treatment options *offered by the team*
1. Pertinent history for our consult:
* Home situation( location/type of residence/homelessness)
* Living with
* Transportation
* ADL ( feeding, dressing, bathing, etc.)
* IADL ( managing meds, finances, etc.)

**Please organize the above history findings for presentation in rounds using the following table**

|  |  |  |  |
| --- | --- | --- | --- |
| Item of CGA(**C**omprehensive **G**eriatrics **A**ssessment) | Pre – admission status | Current status  | Predicted status |
| Functional status |  |  |  |
| Cognitive status |  |  |  |
| Behavior ( homelessness, substance abuse, hoarding, etc.) |  |  |  |
| Mood |  |  |  |
| Advance Care Planning  |  |  |  |

**Common diagnosis used in geriatrics/pall care consultation:**

*Please use at least 3 of them in your notes:*

Severe debility ( to document GOC)

Delirium

Dementia

Weight loss

Unsteady gait

Anorexia/cachexia syndrome

Frailty

Falls

And symptoms: pain, dyspnea, constipation, anorexia, dysphagia, incontinence