SANFORD GERIATRIC SPECIALTY CARE

No separate referral needed.
Among reasons to contact us:

- ❑ Age 65 or older
- ❑ Living alone
- ❑ Unexpected weight loss
- ❑ Increasing weakness
- ❑ Decreasing mobility
- ❑ Memory complaints
- ❑ Multiple chronic conditions
- ❑ Multiple medications
- ❑ Frequent hospitalizations

APPOINTMENTS IN PERSON OR BY TELEMEDICINE

Our team (geriatrician, social worker, pharmacist) provides a "whole person" assessment which includes:

- Personal health history and review
- Physical assessment, including risk for falls/frailty, cognition and depression
- Behavioral/psycho-social assessment including memory issues and dementia
- Medication therapy management review
- Tele-social work and counseling available
- A personalized care plan to share with other care providers
- Referrals to other providers or services, if needed
- Chronic care management program for those who qualify

Information or appointment: (775) 982-1000 (select option for "geriatrics")

Fax: (775) 982-8041

Updated 11-2021

University of Nevada, Reno
School of Medicine
Sanford Center for Aging

FIND US ON FACEBOOK
@UNRSCA

med.unr.edu/aging
(775) 784-4774
sanford@unr.edu

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Sanford Center for Aging

Comprehensive Geriatrics Assessment Request

Thank you for referring your patient to Sanford Center Geriatric Specialty Clinic. In order to qualify, your patient needs to meet two or more of the following criteria:

- 65 years of age or older
- Involuntary weight loss in past 3 months
- Decrease in mobility in past 3 months
- 3 + chronic conditions
- 2 + hospitalizations in last 6 months
- Living alone
- Increasing weakness in past 3 months
- Memory difficulty/problems
- 5 + routine medications
- Considering move to assisted living

Please have your office staff fax the following documentations and this form.

- **Last clinic office note**
- **Any labs or pertinent diagnostic completed in past 6 months**
- **Updated medication and allergy list**
- **Patient demographics**

Sanford Center Geriatric Specialty Care
775-982-1000 Phone / 775-982-8041 Fax

In order to expedite the process please complete in its entirety.

Patient Name: _____ DOB: _____

Patient Phone Number: _____

Authorized secondary contact (family member, home health nurse, etc.)

Name: _____ Relationship: _____

Phone Number: _____

Referring Provider: _____

Provider Phone: _____ Fax: _____

Reason for Evaluation: _____

Provider Signature: _____

Nothing further is needed once you send the above documentation. Our staff will contact the patient to schedule the appointment.