

AROGA GERIATRIC LIFESTYLE MEDICINE

DR. KIM R MCKENZIE MD FRCP INTERNAL MEDICINE/GERIATRIC MEDICINE

Comprehensive Geriatric Review

The Aroga Geriatric Medicine program provides a medically supervised interdisciplinary program for management of lifestyle linked chronic diseases including dementia. We can provide medical management when necessary but focus on specific, intensive yet sustainable lifestyle interventions to bring diseases under control and provide patients with the tools necessary to take charge of their own bodies.

Comprehensive review of all medical problems, drug usage, functional review including cognition/anxiety/depression and physical examination. Please note that healthy elderly can be assessed for preventative assessment and management if there are no specific concerns at this time.

Please check the following for any specific areas of concern:

- | | | | |
|-----------------------------------------------|-------------------------------------------------|-----------------------------------------------|---------------------------------------|
| <input type="checkbox"/> Cognitive Impairment | <input type="checkbox"/> Caregiver Stress | <input type="checkbox"/> Failure to Thrive | <input type="checkbox"/> Chronic pain |
| <input type="checkbox"/> Recurrent Falls | <input type="checkbox"/> Depression and Anxiety | <input type="checkbox"/> Competency | |
| <input type="checkbox"/> Polypharmacy | <input type="checkbox"/> Elder Abuse/Neglect | <input type="checkbox"/> Bladder Incontinence | |

RELEVANT MEDICAL HISTORY (List recent or new diagnoses, MOST, PPS, etc.):

CLINICAL FEATURES (Describe behavioral or cognitive issues, risk of self-harm, falls, aggression, anxiety, pain, etc.):

HOME SITUATION (Outline if living alone, caregiver status, environmental risks, social issues, abuse or neglect, etc.):

PATIENT REFERRAL (All fields are required)

NAME		<input type="checkbox"/> M <input type="checkbox"/> F
PHN	DATE OF BIRTH	
TELEPHONE	CELL PHONE	
ADDRESS	EMAIL	
DIAGNOSIS		
REFERRING MD	MSP ID #	

MD Signature _____

Please complete all sections and provide and append as much pertinent data as possible. Eg: Lab Reports, Consultant Reports, Imaging Reports, etc. All consult notes will be sent to your office via fax after each patient visit.

PLEASE SEND ALL REFERRALS TO THE CENTRAL FAX/PHONE LINE: 855-404-4017