COACH
Connecticut Older Adult Collaboration for Health

Geriatric Medicine Consultation Form

Pt. ID # _____

Patient Name: _____ **DOB ___/____/_____**

Reason for visit: **Date: ____/____/___**

Memory Loss:
- a) How long? (Stable or worse?)
- b) What is being forgotten? (Names, People, where items are being placed?)
- c) Ever got lost?
- d) Hallucinations or delusional thoughts?

Mood Issues:
- a) Feelings of sadness?
- b) Anxiety?
- c) For how long?
- d) Stable or getting worse?
- e) Ever tried medication to help? If so, what? Why discontinued?

Medication:
- a) Are you experiencing any side effects from your medications? Which one?
- b) Which one of your medications is most important?
- c) Which one would you stop if you could? Why?

Safety Concerns:
- a) Do you drive? How did you get here today?
- b) Have you ever gotten lost? Any accidents, near misses or tickets?
- c) Have you ever left the stove on or burned pots?

Mobility Issues:
- a) Difficulty walking? Use of cane or walker?
- b) Have you had a fall in the past 12 months? Any injury?

Weight loss:
- a) Any difficulty chewing or swallowing your food?
- b) Do you wear dentures?
- c) Have you lost weight?
- d) How is your appetite?

Bowel or Bladder Issues:
- a) Any problems voiding or controlling your urine or bowels?
- b) Any problems with urinary frequency, constipation, or diarrhea?

Insomnia:
- a) Any difficulty falling asleep?
- b) Staying asleep?
- c) Nocturia?
- d) Do you take medication to help you sleep?

Medications:

Advanced Directives Yes ☐ No ☐
- a) Living Will Yes ☐ No ☐
- b) Healthcare Proxy Yes ☐ No ☐

General Exam

HEENT
- a) Temporal wasting
- b) Cerumen impaction
- c) Working hearing aids
- d) Dentition / fit of dentures

Extremities :
- a) Skin (pressure ulcers, evidence of poor wound healing.)

Motor Strength:

Gait evaluation
- a) Stride length
- b) Stride height
- c) Cadence
- d) Path deviation

Balance testing
- a) Side by side
- b) Semi-tandem
- c) Tandem
- d) One leg stand

Data: (Labs and imaging)
- a) TSH:
- b) Albumin:
- c) Vitamin D:
- d) Vitamin B12:

Judgement:

a) **If a ball rolled in front of your car, what would you be concerned about?**
Appropriate ☐ Borderline ☐ Incorrect ☐

b) **If you smelled smoke at home, what would you do?**
Appropriate ☐ Borderline ☐ Incorrect ☐

c) **If you fell at home alone and could not get up, what would you do?**
Appropriate ☐ Borderline ☐ Incorrect ☐

d) **Suppose you are home alone and not expecting anyone. There is a knock on your door about 10 o'clock at night. What would you do?**
Appropriate ☐ Borderline ☐ Incorrect ☐

Social History :

Impression:

Recommendations:

a) ☐ **Cognition**
b) ☐ **Function**
c) ☐ **Medication**
d) ☐ **Nutrition**
e) ☐ **Goals of Care**

Notes: