**DEPARTMENT OF MEDICINE FOR THE ELDERLY – South Sector**

**DAY HOSPITAL (Geriatric Medical Clinic) REFERRALS**

 **Patient Details:**

Patient Name: enter text. Date of Referral:enter text.

CHI:enter text. Home Postcode: enter text.

Referring Ward/ Specialty: enter text. Referring Consultant: enter text.

  **Service Required:** Please note if transport is required this must be arranged by the Patient / Family / Carer: Tel: 0300 123 1236

|  |  |
| --- | --- |
| **Type of review needed: Y /N** | **Transport & Appointment Date: Y /N** |
| **Day Hospital –** Urgent (within 2/52) |  | Own transport |  |
| **Day Hospital – Routine**How Soon? enter text. |  | Ambulance required (please give minimum 2 days notice to allow for bookings) |  |
|  | Appointment Date enter text.  |
| **Site of review needed: Y /N (Home postcode should determine where)** | **Send this completed form to the email address for your chosen site:** |
| **New Victoria Hospital** |  | **NVACH.dayhospital@ggc.scot.nhs.uk** |
| **QEUH** |  | **Day.Hospital@ggc.scot.nhs.uk** |

 **Clinical Information – Please state reasons for this referral:**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| For new assessment | Y/N | For review of progress | Y/N | For review of results | Y/N | Other: enter text. |
| Clinical Information (including specific issues needing addressed at clinic) :enter text. |

 **Referrer Name (print):**Click here to enter text. **Sign:** Click here to enter text. **Designation**: Click here to enter text.