GERIATRIC CONSULT CLINIC PRESENTATIONS

HISTORY
A. Who submitted the consult, and why? Was there a specific question that we are to address? What is bothering the patient?
B. Give the usual HPI information as obtained from patient, primary provider, family, and other informants (e.g., SNF staff, visiting nurses, paid caregivers).
C. Geriatric screening information:
   - Trouble seeing?
   - Trouble hearing?
   - Trouble walking? Falls?
   - Weight loss and appetite?
   - Incontinence?
   - Depression? Anxiety?
   - Confusion? Memory problems? Odd behavior?
D. Is there a stressed caregiver in the picture?

PMH/PROBLEM LIST
Relate it as usual, but give no more detail than necessary. “Functional” diagnoses are fine, too – frequent falls, urinary incontinence, dysphagia, etc.

MEDICINES
And, if not already mentioned, how are they managed? Don’t forget the often pernicious over-the-counter or herbal remedies!

ALLERGIES, FH
As usual, briefly

SOCIAL HISTORY
Who is and was this person? Where does he live, and with whom? Who helps out with things? What is the extent of his social network? Has he had discussions with friends, family or doctors about goals of care or advance directives? Has he named a durable power of attorney for health care? What are his current (or significant past) health-related activities (tobacco, EtOH, recreational drugs)?

REVIEW OF SYSTEMS
The usual (symptoms, complaints not already mentioned).

PHYSICAL EXAMINATION
The usual. Start by giving a vivid visual image of the person as he appears generally (alertness, intellect, grooming and hygiene, impression of vigor or frailty, affect). List pertinent positives and negatives. Details on mental status and mobility will likely be important. MMSE or MoCA and GDS should be reported here.

LABS AND OTHER STUDIES
Report as usual. It’s fine to day “normal” instead of reporting numbers.
IMPRESSIONS AND RECOMMENDATIONS
A. In a pithy sentence or two, describe why the patient is in your clinic today.

B. What are his major problems (and couch them in geriatric, functional terms). Example: “Severe gait impairment with frequent falls due to right knee arthritis, drug-induced ataxia, and deconditioning.”

C. What further diagnostic workup would you like to do? What further data would you like to collect (from social work, family phone calls, etc.)?

D. What therapeutic measures do you want to institute today (e.g., new medications, nursing treatments)?