GERIATRICS MEDICINE CLINIC: SERVICE INQUIRY FORM

Please print out and complete this inquiry form. When completed, the form may be faxed to: Intake Coordinator, Geriatric Medicine Clinic. (402) 559-8228

or it may be mailed to: Geriatric Medicine Clinic
attn: Intake Coordinator
981320 Nebraska Medical Center
Omaha, NE 68198-1320

Upon receiving this form, our intake coordinator will call you to discuss your concerns, answer your questions, and schedule an appointment, if desired.

My Name: ___________________________________________
(Print all information)

Daytime Phone Number(s): (_____)_______________________
(_____)_______________________

Best days/times to call: ________________________________

My relationship to the patient: ___________________________

Patient’s Name: _______________________________________

Patient’s Date of Birth: _________________________________

Patient’s Medical Insurance Providers (circle all providers):

Medicare   Medicare Supplement   Medicaid   Other

I am interested in information about the following services (check all that apply):
Not sure? Click on “Patient Care Programs” for detailed descriptions.

_____Geriatric Assessment

_____Medical Consultation

_____A New Primary Doctor
Urinary Incontinence Treatment
Mental Health Services

I have the following concerns about the patient (check all that apply):

- Cognitive/Memory Problems (forgetfulness, repetition, disorientation, etc.)
- Mood Problems (depression, anxiety, etc.)
- Behavioral Problems (anger, aggression, paranoia, hallucinations, etc.)
- Functional Problems (impairments of self-care skills, safety concerns, etc.)

Physical Problems: (circle all below that apply):
- Medication Side Effects
- Gait/Balance Problems
- Falls
- Vision/Hearing Problems
- Sleep Problems
- Pain
- Loss of bladder control
- Weakness/Fatigue
- Dizziness
- Constipation/Diarrhea
- High/Low Blood Pressure
- Weight loss
- Heart Problems
- Lung/Breathing Problems
- Diabetes

Other concerns I have are:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
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