OhioHealth

John J. Gerlach Center for Senior Health
Geriatric Assessment Questionnaire

PATIENT NAME (Last, First, Middle Initial)			Primary Insurance	ID #
Address			Secondary Insurance	ID #
City	State	Zip Code	County	Email
Home Phone #	Cell Phone #		OK to leave a message? Home: ☐ Yes ☐ No Cell: ☐ Yes ☐ No	
Date of Birth	Age	Sex	Gender identity (optional):	Sexual orientation (optional):

Correct Pronouns (Optional): ☐ She/her/hers ☐ He/him/his ☐ They/them/theirs ☐ Other:

Race: ☐ African-American ☐ Asian ☐ Caucasian ☐ Hispanic ☐ Other:
Primary language: _____

NAME OF SUPPORT PERSON (accompanying patient to appointment)			Relationship	
Address			Email	
City	State	Zip Code	Primary Phone #	Secondary Phone # ☐ Home ☐ Work ☐ Cell
NAME OF FAMILY DOCTOR (PRIMARY CARE PROVIDER)			Office Phone #	
NAME OF SPECIALIST(S) (e.g. Neurologist, Psychiatrist, Neuropsychologist)			Office Phone #	

PREVIOUS COGNITIVE EVALUATION (if applicable)
If Yes, please provide – DATE:_____ LOCATION:_____

REASON(S) FOR YOUR VISIT TO GERLACH CENTER (How can we help?)

☐ Memory Issues or Confusion ☐ Polypharmacy Concerns (taking 5+ medications)

☐ Balance Problems or Falls ☐ Mood Concerns (depression, anxiety, etc.)

☐ OTHER: _____

_____

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CURRENT STATUS:	**SUPPORT:**	**HOME:**
☐ Married	☐ Live alone	☐ One-story home
☐ Widowed	☐ Live with:	☐ Two-story home
☐ Divorced	_____ (Relationship)	☐ Apartment
☐ Separated	_____ (Name)	☐ Retirement community
☐ Single (never married)		☐ Care facility
☐ Partnered with significant other		

ADULT CHILDREN: _____ Number, Names: _____

ADVANCE DIRECTIVE: *(please bring copies of health/mental health related documents to your appointment)*

☐ Healthcare durable power of attorney (name): _____

☐ Living will (name): _____

☐ Guardian (name): _____

HIGHEST LEVEL OF EDUCATION: (please circle)

Grade school: 1 2 3 4 5 6 7 8 9 10 11 12 College: 1 2 3 4 Advance degree (title):_____

MILITARY SERVICES:

☐ Veteran ☐ Spouse of veteran Branch of service: _____

EMPLOYMENT:

☐ Currently employed ☐ Semi-retired ☐ Retired ☐ Self-employed

Type of work/profession:_____ Retirement year: _____

FUNCTIONAL STATUS:

Driving: ☐ Yes ☐ No

Hearing aids: ☐ Yes ☐ No

Legally blind? ☐ Yes ☐ No

Mobility Medical equipment (cane, walker, wheelchair)?

_____

NEEDS ASSISTANCE WITH:

☐ Eating	☐ Dressing
☐ Brushing Teeth/Dentures	☐ Taking Medicines
☐ Walking	☐ Telephone
☐ Getting In/Out of Chair	☐ Cooking
☐ Toileting	☐ Finances
☐ Bath/Showering	

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MENTAL HEALTH/SUBSTANCE ABUSE HISTORY:

Mental Health or Substance Abuse Diagnosis? ☐ Yes ☐ No

Diagnosis_____

Name of provider (psychologist, psychiatrist, counselor) _____

Smoking History: ☐ Never Smoked ☐ Currently Smoking/Packs per day: _____

☐ Cigar ☐ Pipe ☐ Chew tobacco ☐ Quit in year: _____

Do you drink alcohol? ☐ Yes ☐ No

If yes, how much alcohol do you drink weekly? _____

COMMUNITY SERVICES: (currently using)

☐ Meals on Wheels

☐ Transportation

☐ Home health nurse

☐ Physical/occupational/speech therapy

☐ Homemaker

☐ Senior options _____
CASE MANAGER

☐ Personal care aid/home health aid

☐ Emergency response system

☐ Home medical equipment

☐ Adult day care

☐ Passport (medical waiver) _____
CASE MANAGER

☐ Veteran services

ADDITIONAL QUESTIONS:

What do you want your physician to know about you? _____

_____

_____

_____

What are the most important things in your life right now? _____

_____

_____

_____

FORM FILLED OUT BY	**DATE**

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Riverside/John J. Gerlach Center for Senior Health
785 McConnell Dr | Columbus, OH 43214
(614) 566-5858

Physician Exchange of Information Authorization

PATIENT INFORMATION

Patient Name (last, first, middle initial)				
Address		City	State	Zip Code
Date of Birth	Social Security #	Work Phone #	Home Phone	

INFORMATION NEEDED

Date of Service:

☐ Inpatient	_____	☐ All records for the last 12 months
☐ Outpatient surgery	_____	☐ Other (scans, x-rays, labs H&P notes)
☐ Outpatient care center	_____	_____
☐ Outpatient	_____	_____
☐ Other (specify dept.)	_____	_____

SEND TO/RECEIVE FROM

☐ Review only date/time:	☐ Pick up needed date/time:	☐ Mail copies	☐ Fax (614-566-1916)	☐ Verbal Exchange

PRIMARY CARE PHYSICIAN Name:			
Address	City	State	Zip Code
Phone #	Fax #		

REASON NEEDED

☐ Medical treatment	☐ Disability	☐ Other (specify)
☐ Legal reasons	☐ Changing doctor/moving	_____
☐ Employment related	☐ Insurance	_____

AUTHORIZATION AND EXPIRATION

This authorization for release of information is effective until 3 years from the date signed below.

I understand that his authorization may include information concerning testing, diosmosis or treatment of HIV (Human Immunodeficiency Virus), AIDS (Acquired immunodeficiency Syndrome), Psychiatric and/or Drug/Alcohol Treatment that may be in my medical record

I understand that if the person or entity that receives the above information is not a health care provider or health plan covered by the federal privacy regulations, the information descried above may be redisclosed by such a person or entity and will likely no longer be protected by the federal privacy regulations

I understand that treatment or payment of any claims will not be impacted by not signing this form. Research related treatment is strictly voluntary. I understand that by signing this authorization is gives the researcher(s) the permission to use or disclose my personal health information for such research. I understand that my records cannot be released unless I sign this form

As described in the Notice of Privacy of Riverside Methodist Hospital. I understand that I many revoke this authorization in writing at any time, except to the extent that action has been taken by Riverside Methodist Hospital in reliance on this authorization, by sending a written revocation to the address at the top of this form

I hear by authorize Riverside Senior Health Services to disclose to the party (parties) names above, information from my medical records for the reasons and time specified

SIGNATURE OF PATIENT	**DATE**
SIGNATURE OF INDIVIDUAL AUTHORIZED BY PATIENT	**DATE**
RELATIONSHIP TO PATIENT	

PROHIBITION ON REDISCLOSURE: this information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal Regulations (42 CFR Part 2) prohibit you from making any further disclosure of this information except with the specific written consent of the person whom it pertains. A general authorization for the release of medical or other information., if held by another party, is not sufficient for this purpose. Federal regulations state that any person who violates any provision of this law shall be subject to prosecution under Federal Law.

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Family Exchange of Information Authorization

PATIENT INFORMATION

Patient Name (last, first, middle initial)	Date of Birth

SEND TO/RECEIVE FROM

Names (of all persons authorized to receive/review information and/or to provide information)		
NAME	**RELATIONSHIP TO PATIENT**	**PRIMARY & SECONDARY PHONE #**

AUTHORIZATION AND EXPIRATION

This authorization for release of information will expire in 3 years or when the patient is no longer a patient at the Gerlach Center, whichever is sooner. It may be revoked at any time in writing

I hereby authorize Riverside/Gerlach Center for Senior Health/Riverside Methodist Hospitals/OhioHealth to exchange with the party (parties) names above, information from my medical record until the time specified above

I understand that this authorization may include information concerning testing, diagnosis or treatment in my medical record

I understand that if the person or entity involved of the above information is not health care provider or health plan covered by federal privacy regulations, the information described above may be redisclosed by such person or entity and will likely no longer be protected by the federal privacy regulation

I understand that treatment or payment of my claim will not be impacted by not signing this form

I understand that my records cannot be released unless I sign this form

As described in the notice of privacy practices of Riverside Methodist Hospital, I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken by Riverside Methodist Hospital in reliance on this authorization, by sending a written revocation to the address at the top of this form, Attn: administrative assistant

SIGNATURE OF PATIENT	**DATE**
SIGNATURE OF INDIVIDUAL AUTHORIZED BY PATIENT	**DATE**
RELATIONSHIP TO PATIENT	

PROHIBITION ON REDISCLOSURE: this information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal Regulations (42 CFR Part 2) prohibit you from making any further disclosure of this information except with the specific written consent of the person whom it pertains. A general authorization for the release of medical or other information., if held by another party, is not sufficient for this purpose. Federal regulations state that any person who violates any provision of this law shall be subject to prosecution under Federal Law.

CareConnect - Adult Patient Visit

Date of Office Visit: _____ Patient Name: _____ Date of Birth: _____

Medical History **(check if patient has medical history of any of the following)**

- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Cancer
- ☐ Cataracts
- ☐ CHF
- ☐ Clotting disorder
- ☐ COPD
- ☐ Depression
- ☐ Diabetes mellitus
- ☐ Emphysema
- ☐ GERD
- ☐ Glaucoma
- ☐ Heart murmur
- ☐ Hepatitis
- ☐ HIV/AIDS
- ☐ Hypertension
- ☐ Kidney disease
- ☐ Meningitis
- ☐ Myocardial infarction
- ☐ Nerve/muscle disease
- ☐ Osteoporosis
- ☐ Seizures
- ☐ Sickle cell anemia
- ☐ Stroke
- ☐ Substance abuse
- ☐ Thyroid disease
- ☐ Tuberculosis
- ☐ Ulcers (GI)

Comments: _____

Surgical History

- ☐ Appendectomy
- ☐ Brain surgery
- ☐ CABG
- ☐ Cholecystectomy
- ☐ Colon surgery
- ☐ Cosmetic surgery
- ☐ Eye surgery
- ☐ Fracture surgery
- ☐ Hernia repair
- ☐ Joint replacement
- ☐ Prostate surgery
- ☐ Small intestine surgery
- ☐ Spine surgery
- ☐ Valve replacement
- ☐ Vasectomy

Comments: _____

Family History

Relationship	Name	Status	Problem
Mother			
Father			
Sister			
Brother			
Daughter			
Son			
Maternal Aunt			
Maternal Uncle			
Paternal Aunt			
Paternal Uncle			
Maternal Grandmother			
Maternal Grandfather			
Paternal Grandmother			
Paternal Grandfather			

Patient Identification Label

Pt. Name: _____

DOB: _____

CSN#: _____

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