**Committed Healthcare Providers**

Our services are provided by a multi-disciplinary team comprising of:

- Doctor
- Nurse Clinician
- Physiotherapist
- Occupational Therapist
- Medical Social Worker
- Other healthcare professionals (where necessary)

**Who Can Refer To Our Service**

Doctors from:

- Polyclinics
- Restructured hospitals
- Interdisciplinary departments
- Family physicians (or General Practitioners)
What is Geriatric Assessment?

Geriatric Assessment is the process in which a team of healthcare professionals:

- Evaluate and identify medical, functional and social disabilities of the elderly person.
- Provide interventions aimed to prevent further disabilities.
- Help the elderly person and his/her family to identify areas of needs and develop an individualised care plan so that the elderly person can continue to live at home with his/her loved ones.

Who Will Benefit From This Assessment?

Frail older persons aged 65 years and above who have complex health problems. These may include decline in day-to-day function, self-care abilities, mobility, weight loss and decreased appetite.

What Happens At The Clinic?

**First Visit**

- The patient will initially be assessed by a nurse clinician.
- Following this, a doctor will see and examine the patient. The doctor may require some blood tests or special investigations such as X-rays or CT scans to be done.
- As the first visit includes a thorough medical and nursing assessment, the whole process may take up to 2 hours or more.
- It is important that a family member or caregiver involved in the care of the patient to accompany the patient for the first visit to help identify areas of needs and develop an individualised care plan.
- It is required that the patient brings all medications and spectacles during the first visit. It is also advisable to bring along a cardigan as the clinic may be cold.

Geriatric Assessment Clinic addresses the complex needs of the elderly person by providing a multi-disciplinary and comprehensive assessment.

**Return Visit**

- The patient will be reviewed after two (2) weeks unless there is a need for the patient to be seen earlier. He/She can expect to have 2-3 scheduled visits.
- The doctor will communicate the findings, diagnosis and expected plan of management.
- The nurse clinician will advise the family or caregiver on strategies to care for the patient. These may include advice on patient safety, nutrition, coping with difficult behaviours; and where appropriate, referrals to community services such as day care or rehabilitation will be initiated.
- A written plan of action and recommendations will be provided to the patient and caregiver(s).