John J. Gerlach Center for Senior Health

OhioHealth

Thank you for choosing The John J. Gerlach Center for Senior Health

Our physicians are board-certified geriatricians who will work with you and your primary care doctor to address aging-related challenges through the geriatric consultation.

> *The John J. Gerlach Center for Senior Health is an Age-Friendly Health System participant. Which means that we are recognized as a leader in the movement committed to the care of older adults.*

Steps in the Geriatric Consultation

1. Please complete and return the included forms.
2. An Initial telephone conversation with a clinical social worker. During this phone call, you and your preferred support person will have the opportunity to identify areas of concerns and discuss what matters to you. Your social worker can also start the process of referring you to community services (e.g. home care, delivered meals, counseling, etc.) at the time of the call.
3. A medical examination with a geriatric physician, a registered nurse and a licensed social worker. This appointment will last approximately 2 hours.

   IMPORTANT: Please bring all your prescription medication, over-the-counter medications, vitamins and supplements, glasses, hearing aids, and ambulatory devices such as cane, walker, or wheelchair to the exam. We do have wheelchairs available on site.

Note that additional testing may be required after the visit and follow-up appointments may be scheduled.

Complete and return forms

The following forms must be **COMPLETED AND RETURNED BEFORE the the phone call with the social worker.** You may complete the forms within MyChart or return the forms via email to SeniorHealth@ohiohealth.com or fax the forms to 614-566-1916.

+ **Pre-visit questionnaire**
+ **Family Exchange of Authorization Form** – if you wish to have your medical information released to specific support people, please list the names of your support people here, and sign the form.
+ **Physician Exchange of Information Authorization** – complete the highlighted areas; the patient or the designated Healthcare Power of Attorney (if patient is medically unable to sign) must sign this form. Please enclose a copy of the Healthcare Power of Attorney document if the patient is unable to sign.

NEED MORE INFO?

Riverside Methodist Hospital
John J. Gerlach Center for Senior Health
785 McConnell Dr
Columbus, OH 43214
(614) 566-5858 | F: (614) 566-1916

To learn more visit OhioHealth.com/Gerlach

OhioHealth

How to prepare for your visit

Complete and return the included forms as soon as possible.

Please bring the following to your appointment:

- Photo ID
- Insurance cards
- Advance directives (power of attorney for healthcare, living will)
- Prescription medications in the original containers
- Over-the-counter medications
- Vitamins and supplements
- Glasses
- Hearing aids
- Ambulatory assistive devices such as cane or walker that are currently used

See enclosed map for directions to our office

PLEASE NOTE: if you must cancel, please give as much notice as possible so that we can offer the appointment time to another patient. In order to ensure that your time with the geriatrician is effective, we may have to reschedule your appointment if you are more than 15 minutes late.

We prefer to meet with you in person, however, telehealth appointments are now available. We encourage you to sign up for MyChart so that you have access to telehealth visits. With MyChart access, you can also manage and receive information about your health via the internet. We will happily assist you with MyChart sign up.

OhioHealth

Frequently asked questions:

Do I need to bring a family member or other support person with me to the visit?

Yes, please bring one family member or one support person with you to the appointment. Up to two people may attend the consultation with you. Additional support people can be tele-conferenced into the visit if requested and after you sign a release of information form.

How much does this cost?

Our appointments are covered by most insurance plans including Medicare/Medicare Advantage plans. If you have a co-pay, the payment will be collected at the time of your visit. We accept credit card and debit cards. We can no longer accept cash or checks.

Will a memory evaluation be completed during the geriatric consultation?

This will be determined by the geriatrician - if appropriate a registered nurse or social worker will conduct a memory evaluation (paper and pencil test) at the beginning of the visit. The geriatrician will review the results with you during your appointment.

Will there be further testing or labs ordered?

Additional testing may be required after the visit. Our nurses will guide you through the process. You will also be given a written summary of follow-up appointments.

Should I bring over-the-counter medications and supplements with me?

Yes – please bring ALL of your medications and supplements in the original bottles to your appointment. The geriatrician will take a close look at these and how they may be affecting your cognition, memory, and general health.

Should I wear my glasses and hearing aids to the appointment?

Yes, these items will be helpful to you as you complete the evaluation.

Will the geriatrician share the recommendations and treatment plan with my primary care provider?

Yes, the geriatrician's and social worker's notes and recommendations will be shared with your primary care provider. You will also be able to view these notes within your MyChart portal. If there is something that you wish to remain confidential please notify the provider.

May my family and I meet with the social worker after the Geriatric exam?

Yes, social workers will be available to assist you and your family as needed with discussions about long term planning, community resources, caregiver education and support. Outside of the doctors' visit, additional social work visits can be scheduled in our clinic or concerns can be addressed by phone.

Will the geriatrician want to see me for a follow-up visit?

This is something you will decide with the geriatrician. Most of our patients return for a yearly follow-up. Some may return sooner. You are able to schedule your follow-up before you leave the clinic.

OhioHealth

Directions

From the North

Take 1-71 south to 1-270 west to route 315 south. OR take route 23 south to 1-270 west to route 315 south. OR take route 33 south to 1-270 east to route 315 south. Follow route 315 south to the North Broadway exit. At the traffic light, turn right onto Olentangy River Road. McConnell Drive is approximately ¼ mile north of the Riverside Methodist Hospital campus on the west (left) side of the street. Turn left at the traffic light onto McConnell Drive and follow the signs to the Neuroscience Wellness Center.

From the South

Take 1-71 north to route 315 north. OR take route 33 north to I-270 west to 1-71 north to route 315 north. OR take route 33 north to 1-70 west to 1-71 north to Route 315 north. Follow route 315 north to the North Broadway exit. Bear right and continue to the traffic light at Olentangy River Road. Turn left onto Olentangy River Road. McConnell Drive is approximately ¼ mile north of the Riverside Methodist Hospital campus on the west (left) side of the street. Turn left at the traffic light onto McConnell Drive and follow the signs to the Neuroscience Wellness Center.

From the East

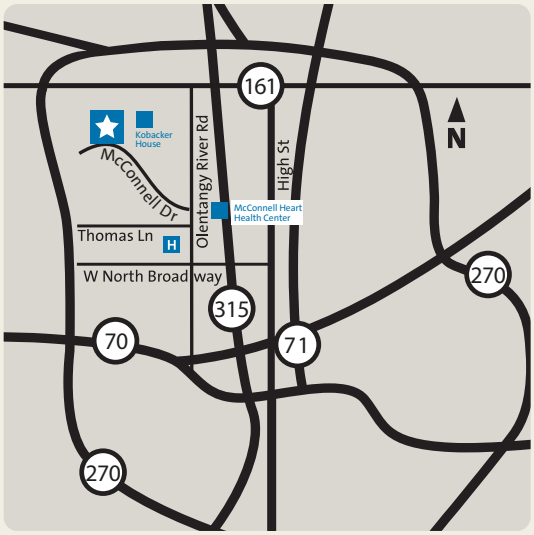
Take 1-70 west to route 315 north. Follow route 315 north to the North Broadway exit. Bear right and continue to the traffic light at Olentangy River Road. Tum left onto Olentangy River Road. McConnell Drive is approximately ¼ mile north of the Riverside Methodist Hospital campus on the west (left) side of the street. Turn left at the traffic light onto McConnell Drive and follow the signs to the Neuroscience Wellness Center.

From the West

Take 1-70 east to route 315 north. Follow route 315 north to the North Broadway exit. Bear right and continue to the traffic light at Olentangy River Road. Tum left onto Olentangy River Road. McConnell Drive is approximately ¼ mile north of the Riverside Methodist Hospital campus on the west (left) side of the street. Turn left at the traffic light onto McConnell Drive and follow the signs to the Neuroscience Wellness Center.

Riverside Methodist Hospital
John J. Gerlach Center for Senior Health
785 McConnell Dr
Columbus, OH 43214
(614) 566-5858 | F: (614) 566-1916

OhioHealth.com/Gerlach



OhioHealth

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	E-mail	
Home Phone #		Cell Phone #		OK to leave a message? ☐ Yes ☐ No	☐ Home ☐ Work ☐ Cell
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					E-mail
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

☐ Balance Problems or Falls

☐ OTHER: _____

☐ Polypharmacy Concerns (taking 5+ medications)

☐ Mood Concerns (depression, anxiety, etc.)

OhioHealth

John J. Gerlach Center for Senior Health
Geriatric Assessment Questionnaire

CURRENT STATUS:
- ☐ Married
- ☐ Widowed
- ☐ Divorced
- ☐ Separated
- ☐ Single (never married)
- ☐ Partnered with significant other

SUPPORT:
- ☐ Live alone
- ☐ Live with:

_____
(Relationship)

_____
(Name)

HOME:
- ☐ One-story home
- ☐ Two-story home
- ☐ Apartment
- ☐ Retirement community
- ☐ Care facility

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

OhioHealth

John J. Gerlach Center for Senior Health
Geriatric Assessment Questionnaire

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

FORM FILLED OUT BY	Date

OhioHealth

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

Physician Exchange of Information Authorization

PATIENT INFORMATION ** Please complete highlighted areas only*

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.

OhioHealth

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

Family Exchange of Information Authorization

PATIENT INFORMATION ** Please complete highlighted areas only*

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.