Pacific Geriatricians Group Inc.

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Vancouver, BC, V5Z 1E9
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PACIFIC GERIATRICIANS GROUP MEDICOLEGAL REFERRAL FORM **FAX 604-620-8724**

Requested Geriatrician

First Available ☐

Specific Physician_____

In order to provide a comprehensive assessment we require all fields be filled out and necessary information provided

Patient Information

NAME: _____ ___

PHN: _____DOB (mm/dd/year): _____

Address: _____

Primary Contact
Name: _____

Relationship: _____ Phone: _____

Reason for Referral

Tick all that apply:

□ Financial Decision Making Capability
□ Personal Decision Making Capability
□ Competency to Complete a Power of Attorney
□ Other:
□ Health Care Decision Making Capability
□ Competency to Complete a Will

_____
_____
_____
_____
_____

Please include the following for all referrals:

Requesting Law Office: _____

Phone: _____ Office Fax: _____

Once your request is reviewed we will contact your law office regarding any clarification and fees for requested services.