**REFERRAL FORM – Mental Health Services**

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| **Referrer Details** | | | |
| Name of Referrer: | | | Date: |
| Residential Aged Care Facility: | | | Resident’s Phone Number/Teleconference: |
|  | | | |
| **Resident Details** | | | |
| Name: | | | DOB: |
| Reason for Referral: | | | |
| Suicide Risk: | No | Yes (Please provide details) | |
| Dementia diagnosis: | No | Yes | |
| Cognitive capacity to engage: | Unknown | Yes | |
| Ruled out delirium: | No | Yes | |
| Gender: | Male | Female  Other (Please specify) | |
| Do they identify as Aboriginal? | No | Yes | |
| Do they identify as Torres Strait Islander? | No | Yes | |
| Marital Status: | Never Married  Widowed  Divorced  Separated  Married | | |
| Medication: | Antipsychotic  Anxiolytics  Sedatives  Antidepressant  Stimulant | | |
| Country of Birth: | Main Language Spoken: | | |
| GP Name: |  | | |
| **Consent for Services** | | | |
| Provided by Resident:  Yes | | | Provided by other:  Yes |
|  | | | Name: |
|  | | | Relationship to resident: |
| **Please send to Lifespan Health:** | | |  |
| Fax:    Email:    Medical Objects:    Telephone: | | | (07) 5406 0829  [referrals@lifespanhealth.com.au](mailto:referrals@lifespanhealth.com.au)  Lifespan Health  (07) 5406 0820 |