**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 0829referrals@lifespanhealth.com.auLifespan Health(07) 5406 0820 |