Referral Form

To be used by Residential Aged Care staff and other health professionals

Think WISE
Psychological support in Residential Aged Care

Resident Details

Name: **Date of Birth:** **Gender:** M / F / Other:

Residential Aged Care Facility:

Does the resident identify as any of the following (please specify)**:**

☐ Aboriginal ☐ Torres Strait Islander ☐ Culturally & Linguistically Diverse (CALD) ☐ LGBTIQ

Primary Language (if other than English):

Next of Kin: **Contact:**

Relationship to Resident:

Referrer Details

Name: **Role:**

Phone: **Email:**

Reason for Referral:

Primary Concern: (Tick all that apply)

☐ Anxiety ☐ Depression ☐ Grief & Loss ☐ Adjustment Difficulties

☐ Behavioural Issues ☐ Trauma ☐ Carer/Family Distress ☐ Other:

Brief Description of Presenting Concern:

Current Supports (e.g., GP, Psychiatry, Social Work):

Unit 7/14 Childers Street, Acton ACT 2601
p: 02 6253 0222 **e:** wise@thinkmh.com.au
thinkmh.com.au

Funded by phn ACT An Australian Government Initiative
Capital Health Network Partnering for better health
WISE Psychological support in Residential Aged Care
Think Mental Health

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Relevant History:

Past mental health diagnosis (if applicable):

Any past mental health treatment (if yes provide details)**:**

Current Health:

General health conditions:

*Nb: Please attach medication list to referral.

Cognitive functioning:

☐ Normal decline ☐ Mild decline ☐ Major decline ☐ Dementia (diagnosed)

If dementia is diagnosed, specify type if known

How does cognitive decline affect resident:

Risk Assessment:

Does resident have a history of aggression towards staff? ☐ Yes ☐ No

If yes, please provide details:

Consent & Privacy:

Is this resident able to consent to this referral? ☐ Yes ☐ No

If yes, have they? ☐ Yes ☐ No

If no, is there an Enduring Power Of Attorney in place? and If yes, does this cover health care (including psychological treatment) ☐ Yes ☐ No

Details of Enduring Power of Attorney providing consent:

Name:

Date of referral:

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