

Referral Form

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



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):

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



Referral Form

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



Relevant History:

Past mental health diagnosis (if applicable):

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

Current Health:

General health conditions:

Cognitive functioning:

*Nb: Please attach medication list to referral.

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 (EPA) in place (covering health care and including psychological treatment) Yes No

Details of EPOA:

Name:

Date of referral:

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

thinkmh.com.au

