**Primary Mental Health Care Services in Residential Aged Care Facilities**

**REFERRAL FORM**

*A MHTP is not required to refer to this program however please respond to all the following questions:*

**RESIDENT INFORMATION**

**1.** Name:     **2.** DOB:    /    /      **3.** Gender:

**4.** Marital Status: Single [ ]  Separated [ ]  Married [ ]  Divorced [ ]  De facto [ ]  Widowed [ ]

**5.** Is the resident from a Culturally and Linguistically Diverse background? Yes [ ]  No [ ]

**If yes**, what is their country of birth?

Is an interpreter needed? Yes [ ]  No [ ]  **If yes**, what language?

**6.** Does the resident identify as Aboriginal or Torres Strait Islander? Yes [ ]  No [ ]

**7. This program is not suitable for people experiencing dementia with severe cognitive features, delirium or a severe and persistent mental illness. Is the resident experiencing these issues?** Yes [ ]  No [ ]

**8.** Does the person experience any cognitive impairment? Yes [ ]  No [ ]

**If yes,** please describe:

**9.** Does the resident experience:

Hearing loss: Yes [ ]  No [ ]  Visual Impairment: Yes [ ]  No [ ]  Mobility Issues: Yes [ ]  No [ ]

**RESIDENTIAL AGED CARE FACILITY (RACF) INFORMATION**

**10.** Name:

**11.** Address:

**12.** Resident room number:

**13.** RACF contact name (e.g. clinical lead):       **14.** Phone:

**GP INFORMATION**

**15.** Name:       **16.** Practice name:

**17.** Practice address:

**18.** GP Phone:       **19.** GP Fax:

**20.** If this referral is not being made by the residents GP, the GP must be informed and supportive of the referral. Has this occurred? Yes [ ]  No [ ]

**KEY CONTACTS**

**21.** Does the resident have a substitute decision maker? Yes [ ]  No [ ]

**If yes,** what is their name:       phone (H):       (M):

**22.** Name of resident’s emergency contact:       **23.** Relationship to the resident:

**24.** Emergency contact phone (H):       **25.** (M):

**RISK ASSESSMENT**

In the previous 6 weeks has the resident expressed:

**26.** Suicidal ideation (i.e. thoughts about suicide): Yes [ ]  No [ ]

**27.** Suicidal intent (i.e. intends to act on their thoughts): Yes [ ]  No [ ]

**28.** A suicide plan (i.e. has planned how they would suicide): Yes [ ]  No [ ]

**29.** Is the resident a risk to others: Yes [ ]  No [ ]  **30.** Behave aggressively: Yes [ ]  No [ ]

**31.** Recent substance abuse: Yes [ ]  No [ ]

**If yes,** to any risk items please provide further details:

**If a resident is at acute risk contact 000 or Mental Health Triage on 131465. If a resident is not in crisis, has suicidal ideation AND either intent or plan, is at risk to others, behaving aggressively or had recent substance abuse refer to the Older Persons Mental Health Service.**

**REASON FOR REFERRAL**

**32.** Does the resident have a suspected or confirmed mental health diagnosis? Yes [ ]  No [ ]  **If yes,** what is this diagnosis?

**OR**

Is the resident “at risk” of developing a mental health diagnosis if not provided with psychological support? Yes [ ]  No [ ]

**If yes,** why?

**33.** Has the resident ever received specialist mental health care: Yes [ ]  No [ ]  Unknown [ ]

**If yes,** please provide brief details:

**MEDICAL INFORMATION**

**34.** Please list/attach details of the resident’s current medical issues and any significant previous medical concerns:

**35.** Please list/attach details of the resident’s current medications:

**36. OUTCOME MEASURES**

|  |  |  |
| --- | --- | --- |
| **Measure**  | **Total Score**  | **Date completed:**  |
| Psychogeriatric Assessment Scale (PAS) |       |    /    /      |
| Cornell Scale for Depression (CSD) |       |    /    /      |

**REFERRER DETAILS**

**37.** Name:       **38.** Profession/position:

**39.** Organisation name:

**40.** Phone:       **41.** Fax:       **42.** Date of Referral:    /    /

**ADDITIONAL INFORMATION**

**43.** Please provide any additional comments (optional):

**44.** Have you attached any information to this referral? Yes [ ]  No [ ]

**CONSENT**

|  |  |
| --- | --- |
| **Copy of Referral given to Resident**  | Yes [ ]  No [ ]   |
| **Resident Consent to release information (must complete):**  |
| I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Resident name-please print clearly) understand this referral is for the provision of mental health services. This process involves an assessment and the development of a plan for treatment. I agree to be part of the process with the knowledge that:* This referral will be processed by the Central Referral Unit at the Adelaide PHN
* My medical history will be shared with the GP and Clinician of the service chosen and

personnel of the chosen service where relevant;* The information collected is private and will be kept confidential unless agreed upon

by all parties to be shared;* My GP/health professional completing the referral has explained to me the reasons for

seeking counselling/therapeutic input;* No Medico Legal Reports will be provided;
* I understand that my treatment will be monitored and communicated between my

treatment team. * All personal information gathered will remain confidential and secure with my treating

team and within the clinical management system hosted by the funding body APHN Therefore, in complying with the principles governing provision of this service we seek your consent.**Resident signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_**Substitute Decision Maker:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_(If signed on behalf or in addition to client by carer / family member / guardian / substitute decision maker)**Relationship of Substitute Decision Maker to Resident:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Referrer Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****Referrer Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_ |

**PLEASE CHECK ALL QUESTIONS HAVE BEEN ANSWERED BEFORE FAXING THE REFERRAL FORM TO THE PMHCS CENTRAL REFERRAL TEAM ON: 1300 580 249**