

SEMPHN Mental Health Referral Form

Residential Aged Care Facilities Psychological Services

Date:		Fax to: SEMPHN Access & Referral 1300 354 053
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Referrer Details	
Full Name:	Profession/Job title:
Phone:	Fax:
Email address:	
Residential Aged Care Facility Name:	
Address:	
State:	Postcode:

Resident Details	
Full Name:	Level of patient mental health need: <input type="checkbox"/> At risk <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe
Date of birth:	NDIS Participant: <input type="checkbox"/> Yes <input type="checkbox"/> No
Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Other	Interpreter required: <input type="checkbox"/> Yes <input type="checkbox"/> No
Aboriginal and Torres Strait Island status: <input type="checkbox"/> Neither Aboriginal or Torres Strait Islander origin <input type="checkbox"/> Both Aboriginal and Torres Strait Islander origin <input type="checkbox"/> Aboriginal but not Torres Strait Islander origin <input type="checkbox"/> Not stated / inadequately described <input type="checkbox"/> Torres Strait Islander but not Aboriginal origin	

Reason for Referral
<i>(Please detail the reason for referral)</i>

Risk Assessment
<i>(Consider suicidal ideation, suicide history, risk of self-harm, risk to others)</i>

Assessment		
Diagnosis of mental illness	<input type="checkbox"/> No	<input type="checkbox"/> Yes <i>(Please provide detail)</i>
Dementia diagnosis	<input type="checkbox"/> No	<input type="checkbox"/> Yes <i>(Please provide detail)</i>
Cognitive capacity to engage	<input type="checkbox"/> Unknown	<input type="checkbox"/> Yes
Assessed for the likelihood of delirium	<input type="checkbox"/> No	<input type="checkbox"/> Yes <i>(If yes, was delirium present? Please provide detail)</i>

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Consent

I, _____ give consent for:

The South Eastern Melbourne PHN (SEMPHN) to seek, collect and share information about my health and wellbeing and for this information to be disclosed to the health provider(s) to whom I will be referred:

Yes No

Resident Signature	
Date	

I, _____ have discussed the proposed referral(s) with the resident, and I am satisfied that the resident understands the proposed uses and disclosures, and the resident has provided their informed consent for these proposed uses and disclosures.

Referrer Signature	
Date	

Fax this referral form to SEMPHN Access & Referral on:

Fax: 1300 354 053

For enquiries, call SEMPHN Access & Referral on **1800 862 363** or visit **semphn.org.au/access**

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