Mental Health in Residential Aged Care Facilities Referral Form

Please complete this form and return via email to: mhracf@gph.org.au

Section 1 – Residential Aged Care Facility Information

Facility Name:

Region: (Northern Beaches, Ryde or Hornsby)

Address (*incl. Room Number*):

Referrer Name:

Referrer Phone:

Referrer Email:

Date of referral:

Section 2 – Resident's Information

Resident Full Name:

Date of Birth:

Gender (M / F / Other):

Phone:

Country of Birth:

Date of entry into RACF:

Interpreter Needed: Yes No
If yes, language required:

Cultural background/ethinicity:

Section 3 – Identity and Relationship Status

Does the resident identity as any of the following:

Aboriginal
Torres Strait Islander
Both Aboriginal and Torres Strait Islander
Neither
Prefer not to say

Heterosexual
Gay or Lesbian
Bisexual
Prefer not to say

Relationship Status:

Never Married/Single
Widowed
Married
Separated
Divorced
Prefer not to say

Section 4 – Reason for Referral

Presenting Concerns (*must be answered*)

Does the resident have an existing mental health diagnosis? Yes No

If yes, please specify, including reason for referral:

Psychogeriatric Assessment Scales score (*must be answered*)

(To be eligible for MHRACF, scoring must be between 0-12): Date completed:

Does the resident have a cognitive impairment or experienced recent deterioration in cognition? Yes No

4AT score (required):

Delirium present (To be eligible for MHRACF Delirium must not be present): Yes No

Section 5 – Further Information

Is the resident currently under an active Enduring Guardianship? If yes, provide details below Yes No

Has the resident/Enduring Guardian consented to being referred for mental health support? Yes No

Does the resident have family/carers involved in their support? If yes, provide details below Yes No

Does the resident have a vision or hearing impairment? Yes No

Does the resident have a current GP Mental Health Treatment Plan? Yes No

Is the resident currently receiving support from any other mental health services? Yes No

Additional Details / Comments e.g. Physical health concerns, family support:

Section 6 – GP Information

GP Practice Name:

GP Name:

GP Phone:

GP Email:

Section 7 – Referrer Declaration

I confirm that the information provided in this referral is accurate and that the resident has been advised of the referral and has given their informed consent.

Date:

Resident signature:

Referrer Signature: