**REFERRAL FORM**

**Wellbeing & Positive Ageing**

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Referrer Details** | | | | | | | | | | |
| Name of Referrer: | |  | | | | Date: | | |  | |
| Position: | |  | | | | RACF: | | |  | |
| Email: | |  | | | | Phone Number: | | |  | |
|  | | | | | | | | | | |
| **Resident Details** | | | | | | | | | | |
| Name: | |  | | | | DOB: | | |  | |
| Reason for Referral: | | | | | | | | | | |
| Suicide Risk: | | No | | | Yes | | | | | |
| If yes, please provide details: | | | | | | | | | | |
| Dementia diagnosis: | | No | | | Yes | | | | | |
| Cognitive capacity to engage: | | No | | | Yes | | | Unknown | | |
| Ruled out delirium: | | No | | | Yes | | | | | |
| Medical examination completed: | | No | | | Yes | | | | | |
| Gender: | | Male | | | Female | | Other (Please specify) | | | |
| Do they identify as Aboriginal and/or Torres Strait Islander | No | Yes, Aboriginal | | Yes, Torres Strait Islander | | | | | | Yes, Both |
| Marital Status: | Never Married  Widowed  Divorced  Separated  Married | | | | | | | | | |
| Medication: | Antipsychotic  Anxiolytics  Sedatives  Antidepressant  Stimulant  Other: | | | | | | | | | |
| Country of Birth: |  | | | | | | | | | |
| Preferred Language: |  | | | | | | | | | |
| GP Name: |  | | | | | | | | | |
| **Consent for Services** | | | | | | | | | | |
| Provided by Resident:  Yes | | | Provided by other:  Yes | | | | | | | |
|  | | | Name: | | | | | | | |
|  | | | Relationship to resident: | | | | | | | |

**PLEASE SEND COMPLETED REFERRAL FORM TO:** [intake@lutheranservices.org.au](mailto:intake@lutheranservices.org.au)

|  |  |
| --- | --- |
| ***For office use only.*** | |
| Date referral received: |  |
| Received by: |  |
| Signature: |  |
| Date followed up: |  |
| Followed up by: |  |
| Signature: |  |