

Royal Brisbane & Women's Hospital  
Health Service District

## Older Persons' Mental Health

# Referral Form

### PATIENT IDENTIFICATION LABEL:

UR No.: .....

Surname: .....

Given Names: .....

DOB: ...../...../.....  Male  Female  
(or affix patient ID label here)

### Patient Details: (Please attach any additional information that will be of assistance)

Current Address:

Suburb: Postcode: State:

Phone No: Country of Origin: Language: ATSI:

### Next of Kin or Significant Other Details:

Name: Relationship:

Address:

Phone No: Mobile: Work:

### Referrer Details

### GP Details

Name:

Name:

Organisation & Type:

Address:

Address:

Phone No:

Fax:

Phone No:

Fax:

### Referral Requirements

Does GP agree to referral?  Yes  No

Type of assistance required?

Is patient aware of referral?  Yes  No

Assessment & Recommendation Only

Does patient agree?  Yes  No

Ongoing Management

**Risk Factors / Alerts** (*Violence, suicide, animals, access to weapons, lethal drugs, access to property etc*)

**Presenting Problems:**

**Past Psychiatric History:**

**Past Medical History:**

**Relevant Physical Findings:** (*including Sight and Hearing Impairment*)

**Relevant Investigation Results:** (*including Cognitive Assessment*)

**Current Medications:**

**Planned Discharge Date:** (*if inpatient*)

**Referral Date:**

**Time:**

<MR o178 ><Review date 18/3/2008>



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**To be completed by Older Persons' MHS Staff Only**

Staff Name: \_\_\_\_\_ Designation: \_\_\_\_\_

Mental Health Act Status:  Voluntary  Involuntary Treatment Order  
 Community Treatment Order

Substitute Decision Maker:  Guardian  Administrator  Enduring Power of Attorney

Agencies Involved: \_\_\_\_\_

**Action Taken**  Order Chart  CESA (Client Event Service Application)

Phone call to GP (*please date each call made*)  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Phone call Next of Kin / Substitute Decision Maker (*please date each call made*)  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Phone call other agencies involved (*please date each call made*)  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**PRESENTED AT TEAM MEETING: Doctor: \_\_\_\_\_ Date: \_\_\_\_\_**

**OUTCOMES:**  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Referred patient accepted by service:**  Yes  No  
 Follow-up letter re: acceptance  Referrer notified of Outcome

**Assessment Priority:**  High  Medium  Low

**Instructions for First Visit: (*Risks, family / significant others present*)**  
\_\_\_\_\_

**Referred patient not accepted by service: (*state reason/s*)**  
\_\_\_\_\_  
\_\_\_\_\_