**REFERRAL FORM**

**Wellbeing & Positive Ageing**

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| --- |
| **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

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