



Please attach any recent examination results for the referred patient

ARMADALE OLDER ADULT MENTAL HEALTH SERVICE - REFERRAL FORM

3056 ALBANY HWY, ARMADALE 6112, PO BOX 460,

PH: (08) 9391 2300 FAX: (08) 9391 2329

1. Please complete the following:

Name of Referrer:	Profession:	
Referrer's Contact Address:	Phone No:	
	Date:	
Name of Patient:	Male <input type="checkbox"/> Female <input type="checkbox"/>	DOB:
Address:		Age:
Telephone (Landline/Mobile/Work):		
Employment Status:		
Is the patient aware of the referral?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Has the patient been seen by this referrer?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
	Date Last Seen _____	

2. Please complete the following as applicable:

Next of Kin:	Address:	Telephone:	Mobile:
Carer's name:	Address:	Telephone:	Mobile:
Significant Other/Legal Guardian:	Address:	Telephone:	Mobile:
List any other agencies involved: eg. Meals on Wheels	Name:	Telephone:	Mobile:
Clients Marital Status	Single <input type="checkbox"/> Married/Defacto <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/>		

3. Living Alone? YES NO

Accommodation Type: House/Unit Nursing Home Hostel Retirement Village

Aboriginal **Non-Aboriginal** **Non English Speaking Background**

Interpreter Required?: YES NO **Preferred Language:**

DVA CARD # : _____ **Colour of Card :** _____

4. Is your referral for:

Diagnostic/Medication Review Behaviour Management Psychosocial Reasons
Other (Please specify)

Details regarding current concerns (e.g. risk / severity):

5. Please indicate the *frequency* of experiencing the CURRENT concern/s:

Ongoing through out the day Several times a day At least once a day At least once a week Once a month

**6. Current medications
(Commencement Date / Dose):**

7. Current/Previous diagnoses:

8. Significant Medical History (including current appointments):

Allergies: Yes No

10. Any Additional Information (include current use of aids/equipment/mobility issues):

11. Referral Response Level:

Same Day = Contact Duty Officer Timely = 2 Days Standard = Within 7 Days