







REFERRAL FORM – RESIDENTIAL AGED CARE PSYCHOLOGY PROGRAM

Please provide as much information as possible and leave sections blank if not known.

Please complete both pages.

Date of Referral:		
Residential Aged Care Facility (RACF)	Room no:	
Name of Resident:		
Date of Birth of Resident:		
Date of Admission:		
Reason for Admission to RACF:		
Reason for Referral: Please describe current concerns and any relevant background information: - Symptoms of mental illness - Onset (gradual or sudden) and duration of symptoms - Mental health history of resident and previous treatment - Drug and Alcohol use		
Please describe any risk issues: - Does the resident experience suicidal thoughts, or self-harm? - Does the resident have a suicidal plan or intent to act on these thoughts? - Is there any aggression towards others? - Past history of risk to self or others?		
PAS Cognitive Impairment Score (most recent): Cornell Depression Scale Score (most recent):	Date completed: Date completed:	
Has the resident consented to the referral?	<input type="checkbox"/> Yes <input type="checkbox"/> No	

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 7 Warabrook Boulevard, Warabrook NSW 2304 / PO Box 572, Newcastle NSW 2300
 02 4925 2259  02 4925 2268  info@hunterprimarycare.com.au **ABN** 27 061 783 015
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Aboriginal Health & Wellbeing | Disability & Wellbeing | General Health & Wellbeing | Mental Health & Wellbeing

Have physical causes for behaviour change been ruled out (e.g. delirium, medication side effects)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does the resident have a formal diagnosis of dementia?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is the resident currently receiving input from the Older People's Mental Health Service/ Dementia Support Australia?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Which staff member(s) know(s) the resident best?	
Does the resident identify as any of the following? Please specify: <ul style="list-style-type: none"> • Aboriginal • Torres Strait Islander • Culturally & Linguistically Diverse (CALD) • LGBTIQ 	
Who is making this referral	<input type="checkbox"/> RACF staff <input type="checkbox"/> GP
Key Contact Person(s) at RACF Name: Telephone: Email:	

Please obtain consent from the GP for provision of psychology services for this patient.

GP Name:	
GP Practice Name & Address:	
GP Telephone Number:	
GP Fax number:	
GP Signature / verbal consent:	

**** PLEASE ATTACH MEDICAL HISTORY – LIST OF MEDICAL CONDITIONS AND MEDICATIONS****

Please send the completed referral form to Hunter Primary Care Psychology Services – Residential Aged Care Program: PRIMA@hunterprimarycare.com.au

If you have any questions, please contact the Clinical Manager (Aged Care) on (02) 4925 2259.

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