Lutheran Services
Mental Health

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

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