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
Any Cultural or Religious Preferences	☐ No	☐ Yes (Please specify)			
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:
	Phone Number:
	Relationship to resident:

PLEASE SEND COMPLETED REFERRAL FORM TO: intake@lutheranservices.org.au