When completed please fax to 4796 3095

Queensland Government Queensland Health Institute of Mental Health Services TOWNSVILLE HEALTH SERVICE DISTRICT **OLDER PERSONS MENTAL HEALTH REFERRAL FORM**	**Affix patient label here** **URN:** **Family Name:** **Given Names:** **Address:** **DOB:** **Sex: m / f**

PATIENT DETAILS		
Name:	**Sex: M / F**	**DOB: / / AGE:**
Address:		**Telephone:**
Marital Status: **Country of Birth:** **Language:** **Interpreter Required: Y / N** **Cultural Background:** **Cultural Advisor Recommended: Y / N**	**Living Situation:** **RACF - Y / N** **High** **Low** **Home** **Alone** **With Others** **Current ACAT Y / N** **Level:**	

NEXT OF KIN DETAILS	
Name:	**Relationship:**
Address:	**Telephone:**
EPOA:	

REFERRER DETAILS	**GP DETAILS**
Name:	**Name**
Organisation / Relationship:	**Address:**
Address:	**Telephone:**
Telephone:	**Fax:**
Fax:	**Date of last contact:**
Does patient agree to referral: Y / N	**Is GP aware of referral: Y / N**
Is family aware of referral: Y / N	

Degree of Urgency: **3 Days ☐** **1 week ☐** **Non – urgent ☐**

Presenting problems / reason for referral –

Onset **1-7 days ☐** **1-3 weeks ☐** **3-6 weeks ☐** **>6weeks ☐**

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Cognitive functioning MMSE / MSQ -
Risk Assessment History of self harm / Harm to others
Past Psychiatric History:
Medical History:

Current MEDICATIONS: □ as per attached	**DOSE:**

Recent Alterations / Allergies / Reactions:
Any recent pathology investigations? Please attach results
Other information attached? Yes….□ No……□
If Yes, what? :
Name:
Designation:

Signature:	**Date:**