AgeWise Referral Form

*To be completed by referrer (self-referrals accepted). Complete all sections of this form and return this form to* *referrals@richmondtas.com.au**. For more information, please contact 03 6228 3344.*

***We are not a crisis service. If immediate support is required, please contact:***

|  |  |  |  |
| --- | --- | --- | --- |
| Emergency Services | Mental Health Services Helpline (24 hr) | Suicide Call Back Services | Lifeline (crisis counselling 24 hrs) |
| 000 | 1800 332 388 | 1300 659 467 | 13 11 14 |

|  |  |
| --- | --- |
| Has the Participant given consent to share their information with us? | [ ]  Yes [ ]  No |
| Has the Participant been in any other Richmond Futures program? | [ ]  Yes [ ]  No |

## Participant Details

|  |  |
| --- | --- |
| **Name:** |  |
| **Date of birth:** |  | **Country of birth:** |  |
| **Gender:** | [ ]  Male [ ]  Female [ ]  Other  |  |
| **Residential facility:** |  |
| **Postcode:** |  | **Phone number:** |  |
| **Marital status:** | [ ]  Never married[ ]  Married (registered / de facto)[ ]  Separated | [ ]  Divorced[ ]  Widowed | **Health Care Card?** |
|  [ ]  Yes [ ]  No |
|  |
| **Preferred language:** |  | **Requires interpreter?** | [ ]  Yes [ ]  No |

## Next of Kin

|  |  |  |  |
| --- | --- | --- | --- |
| **Name:** |  | **Relationship:** |  |
| **Email address:** |  | **Phone number:** |  |
| a Power of Attorney? [ ]  Yes [ ]  No | an enduring Guardian? [ ]  Yes [ ]  No |
| *If* ***“yes”*** *to the above, please complete below:* |  |
| **Name:** |  | **Phone/email:** |  |

|  |
| --- |
| **Reason for Referral:** |
|  |
|  |

*Please tick any that is/are applicable to the Participant:*

|  |  |  |  |
| --- | --- | --- | --- |
| [ ]  | at risk of harm to themselves or others | [ ]  | had a deterioration in mood and/or behaviour |
| [ ]  | feels unsafe or vulnerable | [ ]  | significant event has occurred in the past 12 months (*e.g., recently entered residential care, deterioration, bereavement, etc.).* |
| [ ]  | requests support |
| [ ]  | has a long term/chronic issue |

## Service Providers

|  |  |  |  |
| --- | --- | --- | --- |
| **Doctor/GP:** |  | **Phone/email:** |  |

|  |  |
| --- | --- |
| Is Participant engaged with other health / mental health services?*(e.g., older persons mental health, dementia support, NDIS, etc.)* | [ ]  Yes [ ]  No [ ]  Not known |
| *If* ***“yes”*** *to the above, please specify:* |
|  |
|  |

## Background Information

|  |  |
| --- | --- |
| Does Participant have any mental health / significant diagnosis?*(e.g., Parkinson’s, bipolar, schizophrenia, etc.)*  | [ ]  Yes [ ]  No [ ]  Not known |
| *If* ***“yes”*** *to the above, please specify:* |
|  |
|  |

## Referrer Details

|  |  |  |  |
| --- | --- | --- | --- |
| **Name:** |  | **Relationship:**  |  |
| **Address:** |  | **Organisation:**  |  |
| **Email:** |  | **Phone:** |  |
| **Signature:** |  | **Date:** |  |