Richmond Health

Resident Mental Health Program Referral Form

Referrer Details (self-referral, medical practitioner, family member, support worker, nurse):	
Date of Referral:	
Name:	
Agency/Position/Relationship to the resident:	
Phone Number:	
Email Address:	
Client Details:	
Name:	
Name of Facility:	
Phone Number:	
Gender:	Date of Birth:
Aboriginal or Torres Strait Islander origin? Yes / No / Prefer Not to Say	
Has this referral to Richmond Health been discussed with the Resident? Yes / No	
Next of Kin	
Name:	
Phone Number:	
Email Address:	
Relationship:	
Additional Health Information:	
Mental Health Concerns:	

Previous Mental Health History, if known:
Medications Prescribed:
Are there any current or previous risks such as self-harm, violence, recent falls or illness?
Physical conditions & mobility:

Other Services

Please list any other services involved:

Signed:	Date:
Name:	

Please be aware that this information will not be discussed with the referring person or service without the consent of the client.

Please email this completed form to referrals@rftas.org.au

For additional information, please visit our website or contact our office:

rft.org.au | (03) 6228 3344