AgeWise Program Referral Form

Has this referral to Richmond Fellowship Tasmania been discussed with the Resident?

☐ Yes ☐ No

(Please note: a referral will not be accepted unless the Resident is consenting to the referral).

Has the Resident previously been a client of Richmond Fellowship Tasmania? ☐ Yes ☐ No

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:	

Aged Care Resident Details:					
Resident Name:					
Date of Birth:		Country of Birth:			
Gender:	☐ Male	☐ Female	Other:		
Postcode of Residential Facility:					
Name of Residential Facility:					
Resident's Phone Number:		Health Care Card:	☐ Yes	☐ No	
Main Language Spoken:	**Marital Status:**	**Source of Income:**			
	☐ Widowed	☐ Disability Support Pension			
If main language spoken is not English, what is the resident's proficiency in spoken English:	☐ Married (registered and de facto)	☐ Other pension or benefit (e.g. Aged Pension)			
	☐ Never married	☐ Compensation payments			
	☐ Divorced	☐ Other (e.g. superannuation, investments etc.) / Nil income			
☐ Very well	☐ Well	☐ Separated	☐ Paid employment-full-time		
☐ Not well	☐ Not at all		☐ Paid employment- part-time		
Next of Kin:					
Name:		Relationship:			
Phone Number:		Email:			

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Care Planning: (Please list details of all services involved)				
GP Name:		GP Phone:		
Resident has a GP Mental Health Treatment Plan:		☐ Yes	☐ No	☐ Not known
☐ Older Person's Mental Health:				
☐ Dementia Support Australia:				
☐ NDIA:				
☐ Other:				

Medications:	Client is from a vulnerable population group:
☐ Antidepressants	☐ Not from a vulnerable population group
☐ Antipsychotics	☐ Migrant or refugee
☐ Anxiolytics	☐ LGBTQIA
☐ Hypnotics and sedatives	☐ Aboriginal
☐ Psychostimulants and nootropics	☐ Torres Strait Islander
☐ None of the above	☐ Homelessness (at risk of, or history of)
	☐ Victim/Survivor of family violence or elder abuse
	☐ Has a Disability (physical / cognitive / intellectual / sensory / mental health)

☐ **No mental health concerns listed below**

☐ Anxiety symptoms	☐ Cyclothymic disorder	☐ Attention deficit hyperactivity disorder (ADHD)
☐ Depressive symptoms	☐ Other affective disorder	☐ Conduct disorder
☐ Mixed anxiety and depressive symptoms	☐ Substance use disorders (ATAPS)	☐ Oppositional defiant disorder
☐ Stress related	☐ Generalised anxiety disorder	☐ Pervasive developmental disorder
☐ Alcohol harmful use	☐ Alcohol dependence	☐ Other disorder of childhood and adolescence
☐ Obsessive-compulsive disorder	☐ Other drug harmful use	☐ Adjustment disorder
☐ Post-traumatic stress disorder	☐ Other drug dependence	☐ Eating disorder
☐ Acute stress disorder	☐ Other substance use disorder	☐ Somatoform disorder
☐ Other anxiety disorder	☐ Psychotic disorders (ATAPS)	☐ Personality disorder
☐ Affective (Mood) disorders (ATAPS)	☐ Schizophrenia	☐ Social phobia
☐ Major depressive disorder	☐ Schizoaffective disorder	☐ Anxiety disorders (ATAPS)
☐ Dysthymia	☐ Brief psychotic disorder	☐ Panic disorder
☐ Depressive disorder NOS	☐ Other psychotic disorder	☐ Agoraphobia
☐ Bipolar disorder	☐ Separation anxiety disorder	☐ Other mental disorder

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Risk Assessment: (This information will assist us to prioritize the needs of Residents and respond in an appropriate timeframe. Please note that we are not a crisis service. If immediate support is required, please refer to the services listed end of this referral form).

High Priority

- ☐ Resident is at risk of harm to themselves or others.
- ☐ A recent event has occurred which requires prompt support (e.g. Entered residential care within the past 12 months/ new health diagnosis/ deterioration in health/ recently bereaved).
- ☐ Resident feels unsafe or vulnerable

Medium Priority

- ☐ Resident has had a deterioration in mood and/or behaviour and is requesting support.
- ☐ Resident has a long term/chronic issue and is requesting support

Low Priority

- ☐ Resident has a long term/chronic issue but motivation to engage in mental health support is limited or unknown
- ☐ Resident is not showing signs of risk to self or others, or of deterioration in mood, but is requesting support.

Is this resident a male over the age of 85 years old: ☐ Yes ☐ No

Please describe if there has been a history of suicide attempt; or what risk factors are present, and what supports are in place:

Reason for Referral:

Please send the completed referral form to: referrals@richmondtas.com.au

You may be contacted by our friendly intake staff for more information if there are sections of this form that are incomplete.

For further enquiries please contact head office on 03 62283344.

Crisis Response Services	
If someone is at immediate risk or in danger call Tasmania Police	000
Mental Health Services Helpline (24 hr)	1800 332 388
Lifeline (crisis counselling 24 hr)	13 11 14
Suicide Call Back Service	1300 659 467