



**OLDER PERSONS  
MENTAL HEALTH SERVICE  
REFERRAL FORM**

**Cairns, Innisfail,  
Mossman, Tablelands**  
1A Water St,  
Cairns, Qld, 4870  
Phone: (07) 42263543  
Fax: (07) 42263546

Date: \_\_\_\_\_

**Surname:** \_\_\_\_\_ **Given Name:** \_\_\_\_\_

**D.O.B:** \_\_\_\_\_ **Gender:**  Male  Female

**Residential Address:** \_\_\_\_\_ **Phone Number:** \_\_\_\_\_

\_\_\_\_\_

**Next of Kin/Main Contact Person:** \_\_\_\_\_

\_\_\_\_\_

**Accommodation Type:**  Pvt Residence  Hostel  Res Aged Care Facility  Other

**Lives alone:**  Yes  No **Access Hazards:** \_\_\_\_\_

**Marital Status:**  Married  Widowed  Never married  Separated  Divorced  
 Not stated/unknown  Defacto

**Indigenous Status:**  Aboriginal  Torres Strait Islander  Non Indigenous  
 Unknown/Not stated.

**Preferred Language:** \_\_\_\_\_ **Interpreter:**  Yes  No

**Previous Contact with this Service:**  Yes  No.

**GP Referrer Details:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Phone \_\_\_\_\_

**Client informed of referral**  Yes  No

**Family informed of referral**  Yes  No

**Is client known to Aged Care Assessment Program:**  Yes  No

**Reason for Referral:**

- Psychiatric Assessment & Recommendation only.
- Short term review.
- Medication review.
- Behavioural management strategies.
- Other \_\_\_\_\_

**Main Presenting Complaint:** (Behaviour, mood, perception, sleep, appetite)

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**Duration:**

**Specific Concerns:**

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**Previous History – Medical**

1. _____	1. _____
2. _____	2. _____
3. _____	3. _____
4. _____	4. _____
5. _____	5. _____

**Psychiatric:**

**Current Medications and Dosages: (or attachment)**

1. _____	6. _____
2. _____	7. _____
3. _____	8. _____
4. _____	9. _____
5. _____	10. _____

**Physical Status and Concerns:**

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**Recent Investigations: (please attach copy of recent results)**

FBC TFT U&E LFT B12/folate CT ECG MSU

**Date:** \_\_\_\_\_ **Signature:** \_\_\_\_\_ **Name:** \_\_\_\_\_

**Is patients GP aware of the referral:** Yes No

**Reason NFA:**  Does not meet criteria  Out of Area  Already Managed by MHS  
 Client Deceased  Other  Client Refused Treatment

**Referred to:** \_\_\_\_\_