## Armadale Older Adult Mental Health Service – Referral Form

Email: [AHS.OlderAdultCommunityReferral@health.wa.gov.au](mailto:AHS.OlderAdultCommunityReferral@health.wa.gov.au)

Phone: (08) 9398 6600 Fax: (08) 9394 0845

Post: PO Box 460 ARMADALE WA 6992

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| **Doctor/Referring Agency details** | |
| Name: Click or tap here to enter text. | Telephone: Click or tap here to enter text. |
| Address: Click or tap here to enter text.  Suburb: Click or tap here to enter text.  Post code: Click or tap here to enter text. | Fax: Click or tap here to enter text. |
| Is consumer aware of referral: Yes  No | |

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| **Client Details** | |
| Name: Click or tap here to enter text. | Date of Birth: Click or tap to enter a date. |
| Gender: Male  Female  Other | Dependents: Click or tap here to enter text. |
| Address: Click or tap here to enter text.  Suburb: Click or tap here to enter text.  Post code: Click or tap here to enter text. | Telephone: Click or tap here to enter text.  Preferred contact time: Click or tap here to enter text. |
| Ethnicity: Aboriginal/Torres Strait Islander   Other  Click or tap here to enter text. | Language/s spoken: Click or tap here to enter text. Interpreter Required: Yes  No |
| Next of Kin/Significant other contact details:  Name: Click or tap here to enter text.  Relationship to the patient: Click or tap here to enter text.  Telephone: Click or tap here to enter text.  Address: Click or tap here to enter text.  Suburb: Click or tap here to enter text.  Post code: Click or tap here to enter text. | Is there an appointed Legal guardian? Yes  (please provide details) No  Name: Click or tap here to enter text.  Telephone: Click or tap here to enter text.  Address: Click or tap here to enter text.  Suburb: Click or tap here to enter text.  Post code: Click or tap here to enter text. |
| Living alone: Yes  No  Accommodation type:  House  Nursing Home  Hostel  Retirement Village | Current use of aids/equipment/mobility issues: Yes  (please specify) No  Click or tap here to enter text. |

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| **Level of urgency:** |  | |  |
| Emergency  Call **000/**AHS Emergency Department | | Urgent  Call OA triage (08) 9398 6600 | Routine  Fax or Email AMHS (details above) |

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| **Reason for referral** (select all that apply)  Diagnostic clarification  Opinion on diagnosis and management |
| Medication review  Risk assessment and management |

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| **Clinical details**  Brief history: Click or tap here to enter text. |
| Drugs and alcohol use history (including interventions): Click or tap here to enter text. |
| Allergies: Click or tap here to enter text. |
| Past medical history: Click or tap here to enter text. |
| Mental state examination: Click or tap here to enter text. |
| Risk assessment: Click or tap here to enter text. |
| Previous risk incidents (self harm, suicide attempts, harm to others, other risks): Click or tap here to enter text. |

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| **Management**  Recent investigations: (Please fax a copy of all the recent investigations).  Click or tap here to enter text. |
| Medication: (Please provide a list of **all** medications or fax a copy).  Click or tap here to enter text. |
| MH Care Plan: Completed  Not yet completed |

Click here to email  
referral form to AMHS