RACH Referral Form

CARE4MH
A PERSON CENTRED MENTAL HEALTH & PHYSICAL WELLBEING PRACTICE

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This referral form is for the **Residential Aged Care Home Psychological Therapy Program**, available to residents of the following Mackay facilities: **Ozcare St Elizabeth Villa, St Francis of Assisi, Good Shepherd Lodge, Kerrisdale Gardens, and Resthaven on Quarry**.

The program is designed for residents experiencing a non-acute mental health condition or those at risk of developing a mental illness, providing short-term, goal-focused psychological strategies tailored to their needs.

If the person has acute mental health needs, refer to Acute Care Team or Child Youth Mental Health Service via 1300 64 2255

Date of Referral _____

Referrer Details

Referrer Name:_____ **Role/Relationship:**_____

Organisation Name:_____ **Provider Number:**_____

Contact Number:_____ **Fax Number:**_____

Referrer Email:_____

Resident Details

Duration of Residence in RACH_____

Full Name:_____

Date of Birth:_____ **Gender:** _____

Address:_____

Phone:_____ **Email:**_____

Health Care Card? Yes No **Pension Card?** Yes No

Dept Veterans Affairs (DVA) Card? Yes No

Does the person identify as Aboriginal or Torres Strait Islander? Yes No

Proficiency in spoken English: Very Well Well Not Well Not at all

Interpreter required? Yes No **If yes, language:**_____

Referral Information

Reason for referral:_____

_____

Is there a mental health diagnosis? Yes No

*If yes, please specify:*_____

_____

Are there health professionals currently involved in the consumer's care? Yes No

*If yes, please provide details:*_____

_____

Is the individual currently taking medication? Yes No

If yes, please attach the medications chart.

Is there a history of alcohol and/or drug use? Yes No

*If yes, please provide details:*_____

_____

Is there history of suicide and/or self harm? Yes No

If yes, please provide details: _____

_____

Is there a history of aggression or violence? Yes No

*If yes, please explain:*_____

_____

Is there a concern regarding safety, vulnerability, and/or domestic violence? Yes No

*If yes, please provide details:*_____

_____

Is this person a risk to themselves or others? Yes No

*If yes, please explain:*_____

_____

Emergency Contact

Contact in the event of an emergency or if the referred person is unavailable. If the consumer is a child, provide the details of the legal parent or guardian.

Primary Contact:_____ **Role/Relationship:**_____

Agency:_____ **Phone:**_____

Email:_____

Consent To Share Information

In accordance with the Privacy Act 1988 and the Information Privacy Act 2009, your consent is required for the release of information related to this application.

By signing this form, you consent CARE4MH to collect and share information relevant to your application with relevant Local Health District services, your emergency contact, and other service providers involved in your care. This consent ensures that all parties can collaborate effectively to support your mental health needs.

Do you consent? Yes No

Resident **name (or Enduring Power of Attorney):**_____

Resident **signature (or Enduring Power of Attorney):**_____

Date:_____

The referrer agrees that all information submitted in this referral is an accurate and complete, reflecting the applicant's support needs. This information is essential for CARE4MH to effectively fulfill its duty of care to consumers, staff and parter agencies.

Referrer name:_____

Referrer signature:_____ **Date:**_____

What Happens Now

- Email this referral form and any other relevant documents to **referrals@care4mh.com**
- A CARE4MH mental health clinician will conduct an assessment during their next scheduled visit to the resident's aged care facility.