ST VINCENT'S HOSPITAL
SYDNEY
A FACILITY OF ST VINCENT'S HEALTH AUSTRALIA

St Vincent's Hospital Sydney Limited
ABN 77 054 038 872

PSYCHOGERIATRIC MENTAL HEALTH AND DEMENTIA SERVICE

O'Brien Centre, Burton St
Darlinghurst NSW 2010

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E SVHS.Psychogeriatrics@svha.org.au
E SVHS.Dementia@svha.org.au

GP Referral to Psychogeriatric Service

Date Requested: _____/_____/_____

Urgency: *(Please ☑)*

☐ Urgent (within 24 - 48hrs)

☐ Non-Urgent *(as soon as practicably possible)*

Comment: _____

jdwqey12hg

Please Note: Hours of Operation Mon-Fri 8.30am - 5.00pm

Preferable Site of Assessment:
(Please ☑)

☐ Home Visit

☐ RACF

☐ Out Patient Clinic

Referrer's Details:

GP Name: _____

Practice Name: _____

Provider Number: _____

Contact Number: _____

Referral valid:

☐ 12 month referral

☐ Indefinite referral

Preferred method of communication for correspondence:

1) Email: _____

2) Fax: _____

Patient Details:

Name: _____

DOB: _____

Address: _____

Contact Numbers: _____

Medicare Number: _____

Contact Person: _____

Relationship: _____

Contact Details: _____

Reason for Referral: *(Please ☑)*

☐ Mental Health Assessment

☐ Medication Review

☐ Behavioural Issue

☐ Cognitive Assessment / Dementia Diagnosis

☐ Capacity (e.g. for purpose of Guardianship)

☐ Psychological Therapy

☐ Club Bright (group therapy for depression / anxiety)

☐ Club Connect (group cognitive remediation)

☐ Behaviour Management

☐ Carer Support

☐ Psychoeducation

☐ Dementia Nurses

☐ Other: *(Please list below)*

Background Information	
Medical History: Mental Health Diagnosis: Substance Use: Social: Current Functioning & Supports: Cognition: Risk:	Current Medications: Allergies: Clinical Investigations: Delirium Screen *(if applicable)* ☐ Yes ☐ No Comments:
Further Details Regarding Identified Issue/Reason for Referral:	
Signature:	Date: