ST VINCENT'S HOSPITAL MELBOURNE / VICTORIAN ABORIGINAL HEALTH SERVICE *Caring for the Community*	**ST VINCENT'S MELBOURNE** **KOORI UNIT REFERRAL FORM** MENTAL HEALTH	SVHM UR: _____ Surname: _____ Given name: _____ Date of birth: _____ *Please fill in if no Patient Label available*

St Vincent's acknowledges Aboriginal and Torres Strait Islander peoples as the Traditional Custodians of the lands and waters where we live and work. We respect historical and continuing spiritual connections to Country and community and pay our respects to Elders past, present and emerging. As a health and aged care provider, we commit ourselves to the ongoing journey of Reconciliation.

Date of referral:				
Consumer Details				
Name:				
Date of birth:				
Address:				
Phone number:				
Mob/Country: *(if known)* *Include cultural and community connections*				
Referrer Details				
Name:				
Role:				
Organisation:				
Phone:		**Email:**		
Consumer has consented to referral:	☐ Yes ☐ No			
Current Supports				
Consumer is known to VAHS:	☐ Yes ☐ No			
General Practitioner: *Include name, clinic, address address and/or phone number.*				
Other services involved: *Include contacts and indication of ongoing involvement.*				
Emergency Contact Details				
Name:		**Relationship:**		
Phone number:		**Permission to contact:**	☐ Yes	☐ No

KOORI UNIT REFERRAL FORM MENTAL HEALTH – ST VINCENT'S MELBOURNE

SV999058

ST VINCENT'S HOSPITAL MELBOURNE

VICTORIAN ABORIGINAL HEALTH SERVICE
Caring for the Community

ST VINCENT'S MELBOURNE

KOORI UNIT REFERRAL FORM

MENTAL HEALTH

SVHM UR: _____
Surname: _____
Given name: _____
Date of birth: _____
Please fill in if no Patient Label available

KOORI UNIT REFERRAL FORM MENTAL HEALTH – ST VINCENT'S MELBOURNE

Reason for Referral

Include Social and Emotional Wellbeing (SEWB) goals of admission – refer to SEWB Wheel in SVHM Koori Unit Information Sheet for Clinicians

Current Alcohol and/or Substance Use, including Smoking / Vaping History

Current Risk Assessment

Include needs of dependents.

Medical History

Include health summary, if possible.

Current Treatment

Scheduled outpatient appointments, any current psychological treatment (e.g. therapy etc).

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Medication List

Allergies / Adverse Reactions

Helpful Aspects for Handover

Previous experience/s with mental health services

Previous trauma:

Current legal concerns:

Family violence and/or relationship complexities:

Interests of the consumer:

Potential triggers and coping strategies:

Referral form completed by:

Name:		**Date:**	
Designation:			

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