



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:

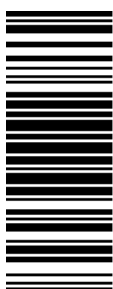
Phone number:

Permission to contact:

☐ Yes

☐ No

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



SV999058



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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.

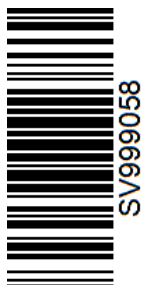
Medical History

Include health summary, if possible.

Current Treatment

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

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Medication List

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Allergies / Adverse Reactions

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Helpful Aspects for Handover

Previous experience/s with mental health services

--

Previous trauma:

--

Current legal concerns:

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Family violence and/or relationship complexities:

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Interests of the consumer:

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Potential triggers and coping strategies:

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Referral form completed by:

Name:		Date:	
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Designation:	
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