



Richmond Fellowship Queensland

SAGE Program Referral Form



Please return the completed form to:

Email: sage@rfq.com.au

For further information, please call:

07 3363 2546

Who We Are

Richmond Fellowship Qld (RFQ) is not for profit community-owned organisation that supports people facing mental health challenges and social disadvantage by providing leading recovery-oriented psychosocial services.

Purpose of the Program

RFQ provides personalised psychological assessment and treatment services to people with mental health needs living in Residential Aged Care Facilities, in the Darling Downs and West Moreton region. The service includes:

- Low-intensity Cognitive Behavioural Therapy (a form of therapy in which individuals learn how to identify and change unhelpful thinking and behaviours)
- 1:1 Occupational Therapy (OT) mental health services, tailored to meet individual need
- Sensory modulation group interventions

Program Eligibility

To be eligible for support the person must:

- Be residing in a selected Residential Aged Care Facility in the Darling Downs/West Moreton region
- Have a diagnosed mental illness OR be experiencing early symptoms of mental illness and be assessed as at risk of developing a mental illness over the next 12 months

Note: People with dementia are not excluded from the service if they also have a comorbid mental illness, such as depression or anxiety. Delirium may present with symptoms similar to those associated with a mental illness although it will not respond to psychological therapies and requires urgent medical assessment.

Confidentiality

RFQ values people's privacy and right to confidentiality and has quality control procedures to ensure the information provided is safeguarded. RFQ adheres to the Australian Privacy Principles (APP's) set out in the Privacy Act 1988, amended by the Privacy Amendment (Enhancing Privacy Protection) Act 2012 through the RFQ Privacy Policy and the RFQ Privacy Collection Statement.

Sending a Referral Form

Please send completed form, marked confidential to sage@rfq.com.au (email is RFQ's preferred method of referral).

Personal Details of Client

Surname		Given names	
Date of birth		Gender	
Address		Phone	

Cultural Needs of Indigenous Australians

Does the client identify as:

- Aboriginal but not Torres Strait Islander origin
 Torres Strait Islander but not Aboriginal origin
 Both Aboriginal and Torres Strait Islander origin
 Neither Aboriginal nor Torres Strait Islander origin
 Other, please specify:

Cultural and Linguistic Diversity

Country of Birth	Year of first arriving in Australia	Main Language Spoken
Interpreter required?	<input type="checkbox"/> Yes <input type="checkbox"/> No	

Decision Making

Please identify if the client has an administrator appointed for decision making? If yes, please identify who has been appointed for each matter:

The Adult Guardian	No <input type="checkbox"/>	Yes <input type="checkbox"/>	
Power Of Attorney	No <input type="checkbox"/>	Yes <input type="checkbox"/>	
Advanced Health Directive	No <input type="checkbox"/>	Yes <input type="checkbox"/>	
The Public Trustee	No <input type="checkbox"/>	Yes <input type="checkbox"/>	
Enduring Power of Attorney	No <input type="checkbox"/>	Yes <input type="checkbox"/>	
Other	No <input type="checkbox"/>	Yes <input type="checkbox"/>	

Next of Kin (NOK)
GP Contact Details

Name		Name	
Relationship		Email	
Address		Clinic address	
Phone number		Phone number	
<input type="checkbox"/> Contact in case of emergency		We routinely liaise with and send correspondence to GP's at the beginning and end of treatment. Please tick this if you do NOT wish for this to occur <input type="checkbox"/>	

Referrer Information and Signature

Name of Referrer		Organisation	
Position		Email	
Office address		Phone	

By signing this form:

I confirm that the client (or if applicable, their interpreter or decision maker), are in agreement with their referral to this program, and have consented to the information in this referral form being provided to RFQ.

Referrer Signature: _____ Date: _____

Please attach further information to inform our assessment and support.

Clinical Information			
Brief reason for referral:			
Please provide details of the person's diagnosed mental illness, OR the early symptoms of mental illness they are experiencing:			
Please list the person's current prescribed medication (attach as required):			
Are there any side effects we need to be aware of?	No <input type="checkbox"/> Yes <input type="checkbox"/>	Details:	
Please provide any information regarding the person's mental health or physical health history that may inform our services for the person (attach as required):	No <input type="checkbox"/> Yes <input type="checkbox"/>	Details:	
Are there any current alerts for this client? For example: health alerts, risks, orders, etc – please list. If so, please provide details of risk management in relation to the alerts (attach as required):	No <input type="checkbox"/> Yes <input type="checkbox"/>	Details:	
Is the person at risk of self-harm, suicide or harm to others?	No <input type="checkbox"/> Yes <input type="checkbox"/>	Details:	
Are there any other health needs that we need to be aware of?	No <input type="checkbox"/> Yes <input type="checkbox"/>	Details:	
Has this referral been endorsed by the GP in regards to clearance from other health issues, such as cognitive decline, or dementia? (Please attach)	No <input type="checkbox"/> Yes <input type="checkbox"/>	Details:	

This service is supported by funding from Darling Downs and West Moreton PHN under the Australian Government's PHN Program.