Te Whatu Ora
Health New Zealand
Te Matau a Māui Hawke's Bay

REFERRAL TO OLDER PERSONS MENTAL HEALTH SERVICE (OPMH)

Fill in only if patient label is unavailable

Name:..... DoB:.....

NHI:..... Phone:.....

Address:.....

.....

REASON FOR REFERRAL: Why would you like this person to be seen now by a specialist service?:

Date of referral:	GP name:
Referred by:	GP phone number:
Date of last medical review:	Seen by:
Next of Kin:	EPOA activated: ☐ Yes ☐ No EPOA Name:

Patient / EPOA **consent** to referral? ☐ Yes ☐ No

Relevant clinical details:

Diagnosis (if known):

Past medical and psychiatric history:

Recent blood screen results:

FBC U&Es LFTs TSH B12 Folate Ca2+ Mg and Phosphate

CRP HBA1C

MSU obtained: ECG (if available):

Cognitive screening tool (if appropriate) with copy attached:

Medication:

Social Factors

Living situation:

Formal supports/agencies involved:

Issues with ADLs, finances or driving:

Other concerns:

Name: ..... Designation: .....

Signature: ..... Date: ..... Time: .....

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