OPALS REFERRAL FORM

Please complete and send this form to OPALSTeam@caxton.org.au
For secondary consultations, please call the OPALS lawyers on 0408 376 117 (Tilé) and/or 0436 125 030 (Anna)

PATIENT/CLIENT DETAILS						CC (Office Use Only)
Name:			DOB:		☐ Male ☐ Female ☐ Other	☐
SAFE PHONE NO:			Address:			
Has the older person consented for OPALS to contact them?				☐ Yes ☐ No		
Urgent Call Back Required?				☐ Yes ☐ No		
Are they in hospital or the community?						
Can we contact the older person directly?				☐ Yes ☐ No		
If No, why?						
What are the safety risks in contacting the older person, if any?						
Can we leave a message for the older person?				☐ Yes ☐ No		
Is an interpreter required?	☐ Yes ☐ No	**Language:**		☐ **Aboriginal** ☐ **Torres Strait Islander**		

Full name of Referrer:			
Location:	☐ **PAH** ☐ **Logan** ☐ **Redlands** ☐ **QEII** ☐ **Community Health** ☐ **Other**		
Phone of Referrer:		**Email of Referrer:**	
Full of Other/Related parties	**DOB** (if known)	**Relationship to older person** (if known)	**CC** (Office Use only)

Type of Abuse: *Please check one or more as appropriate and make a comment*	
☐ **Financial Exploitation**	
☐ **Physical/Emotional**	
☐ **Other or Potential Abuse**	

Other comments:	