cCCHiP INPATIENT REFERRAL FORM

Collaborative Centre for Cardiometabolic Health in Psychosis

Fax : 9767 7107
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Name:	
MRN:	
Ward:	
Sex:	M / F / other:
Indigenous:	Yes / No/ Other:
Date:	
EDD:	

PURPOSE OF CONSULT:

Is the patient aware of the referral?	**Risk Issues:**

PATIENT HISTORY

Has the patient ever been diagnosed with:

Psychosis:	Yes / No
Diabetes:	Yes / No
Hypertension:	Yes / No
Peripheral vascular disease:	Yes / No
Angina:	Yes / No
Heart Disease:	Yes / No
Stroke:	Yes / No

Family history of any of above? Comment**:**

INVESTIGATION RESULTS

Date of results:

Total Cholester-		**Other:** (Apo B/U-ACR/ CRP)
Triglycerides:		
HDL:		
LDL:		
Fasting glucose:		
HbA1c:		
TFTs: NAD or:	TSH: T4: T3:	

MEASUREMENTS

Weight:	
Waist circumference:	
Height:	
BMI:	
Blood Pressure: Comment (e.g. postural hypotension)	

LIFESTYLE

Smoker:

Y/ N

No./day:

EtOH:

Current / Past:

SD /day:

ECG RESULTS

REFERRER DETAILS

Name:

Designation:

Ward:

Pager:

Signature: