MEDICARE CARD NUMBER

Collaborative Centre for Cardiometabolic Health (ccCHiP)
Clinic Assessment Tests - FASTING PREFERRED

PATIENT SURNAME | GIVEN NAMES | SEX | DATE OF BIRTH

ADDRESS | TEL (HOME) | TEL (BUSINESS)

TESTS REQUESTED

Blood: **FBC, UEC, LFT, CMP, TFT, BGL, lipids: TC/TG/HDL/LDL, uric acid, hsCRP, HbA1c, B12, folate**
ApoB [only if BB/no fee]
Urine: **urine albumin to creatinine ratio**

Also if clinically indicated (please tick): ☐ **iron studies** ☐ **25-OH vitamin D**

Drug levels if indicated (**12-h trough**): ☐ **clozapine & norclozapine** ☐ **valproate** ☐ **lithium**

FASTING ☑
RANDOM ☐
Pregnant ☐
Hormone Therapy ☐
LNMP
EDC

CLINICAL NOTES

ccCHiP (Collaborative Centre for Cardiometabolic Health in Psychosis) Clinic Assessment
Indications: **psychotic condition, elevated CVD risk and risk assessment, ? malnutrition, ? medication adverse effect**
Tick relevant: ☐ **Diabetes** ☐ **Overweight/Obesity** ☐ **Poor nutrition** ☐ **? low B12 (e.g., metformin/PPIs/alcohol)**

URGENT! ☐ Phone ☐ Fax ☐ By time:
Phone/Fax no
Private ☐ Schedule ☐ Bulk Bill ☑ ☐ PEN ☐ HCC
Vet Affairs no

REQUEST DATE

COPY TO **ccCHiP Team**
Clinical Sciences Building (20)
Concord Hospital
Hospital Road, Concord 2139

Ph: 02 9767 6027
Fax: 02 9767 7107

REQUESTING DOCTOR
Surname and Initials, Address and Provider Number

COLLECTION CENTRE USE

COLLECTOR TO COMPLETE:
I certify that the blood specimen accompanying this request was drawn from the patient stated as established by direct enquiry of the patient and/or inspection of the ID wrist-band, and that specimen was labelled immediately. I have also signed the sample tube(s).

NAME: _____
SIGN: _____
TIME: _____ DATE: _____

[ ] SST [ ] EDTA [ ] GLU [ ] CIT
[ ] SNG [ ] PNG [ ] ACD [ ] PPT
[ ] HISTO [ ] PAP [ ] TP [ ] URIN
[ ] SWAB [ ] FAEC [ ] SPUT [ ] OTHER

MEDICARE ASSIGNMENT (Section 20A of the Health Insurance Act 1973)
I assign my right to benefits to the approved pathology practitioner who will render the requested pathology service(s).

Practitioner Use Only: _____
(Reason Patient cannot sign)

PATIENT'S SIGNATURE AND DATE
✗ _____ / /

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PATIENT SURNAME | GIVEN NAMES | SEX | DATE OF BIRTH | SURGERY FILE #

ADDRESS | TEL (HOME) | TEL (BUSINESS)

TESTS REQUESTED

FBC, UEC, LFT, CMP, TFT, BGL, lipids: TC/TG/HDL/LDL, uric acid, hsCRP, HbA1c, B12, folate
ApoB [only if BB/no fee]

Urine albumin to creatinine ratio

☐ **iron studies** ☐ **25-OH vitamin D**
☐ **clozapine/norclozapine** ☐ **valproate** ☐ **lithium**

REQUESTING DOCTOR (Surname and Initials, Address and Provider No.)

MEDICARE ASSIGNMENT (Section 20A of the health Insurance Act 1973)

PATIENT'S SIGNATURE AND DATE

By this declaration I assign my right to benefits to the approved pathology practioner who will render the requests pathology service(s). I declare that none of the services claimed in this form relate to an accident, injury or illness which has, or may result in the payment of compensation or damages ...../...../.....