EXTERNAL REFERRAL TO ccCHiP (non-SLHD or GPs)

IMPORTANT! PLEASE READ:

A. There are limitations on receiving referrals during the COVID period. Please consult the front page of http://www.ccChip.clinic for updates regarding referral status.

B. All internal SLHD referrals should use the electronic eReferral system. GPs who have joined the ccCHiP eReferral process should use their HealthLink procedures.

C. **ALL** data fields requested on this form are required for the referral to be accepted for triaging. Unfortunately, reduced capacity due to COVID only allows us to accept a proportion of referrals at present.

Consent: the patient been informed of this referral and agrees to see all team members (psychiatrist, endocrinologist, cardiologist, sleep worker, dietitian, exercise physiologist, dental team, nurse): ◯ Yes ◯ No

GP details

Name: _____

Practice address:

_____

_____

_____

Care Coordinator details

Name: _____

Clinical address (include team if applicable):

_____

_____

Phone: _____

Email: _____

Fax: _____

Psychiatrist details

Name: _____

Practice address/CMHC:

_____

_____

_____

Referrer details

◯ Tick if same as GP

Name: _____

Practice address:

_____

_____

_____

Phone: _____

Provider No.: _____

Referrer signature:

Referral is to duty Psychiatrist, Endocrinologist, and Cardiologist attending the clinic.

Referral must be made by a GP or Consultant -
Please tick who is referring:

◯ GP (12 months/indefinite) or ◯ Consultant (3 months)

Referral Date (DD-MM-YY):_____

Reasons for Referral:

_____

_____

_____

Patient details

Name: _____

Sex: ◯ Female ◯ Male ◯ Other

DOB (DD-MM-YY): _____

Address: _____

_____

Phone: _____

Email: _____

Fax: _____

Health system details

RPA MRN: _____

CRGH MRN: _____

Community MRN: _____

Medicare #:_____

Medicare Ref: _____ Expiry: _____

Pension #: _____

Carer/Next of Kin/Guardian:

_____

Relationship to patient:

_____

Interpreter services

Interpreter required: ◯ No ◯ Yes

If 'Yes', which language? _____

_____

IMPORTANT! PLEASE READ:

A. Please provide as much information as possible to enable faster **triaging.**
B. **All** pathology tests are required by ccCHiP. If any are missing, the patient can not be seen.
C. The patient should be **fasting** for their blood tests.
D. Ensure that pathology request has **copy to: ccCHiP** - the referral system requires this.

Pathology tests to order (all)

- ✓ EUC
- ✓ FBC
- ✓ LFT
- ✓ TFT
- ✓ Serum Uric Acid
- ✓ BGL
- ✓ Apolipoprotein B*
- ✓ Calcium, Magnesium, Phosphate
- ✓ Total Cholesterol/Triglycerides/HDL/LDL
- ✓ High sensitivity C-reactive protein
- ✓ ACR (Urine Albumin Creatinine Ratio)
- ✓ B12 (**if** receiving metformin)
- ✓ Clozapine/NDMC levels (**if** on clozapine)
- ✓ HBA1c

Tick: ◯ diagnostic, 1/year; ◯ diabetic, up to 4/year

*Bulked billed by Laverty and Douglass Hanly Moir

Date blood collection (DD-MM-YYYY):

_____

Pathology lab used:

_____

Patient medical history

Please tick any that have ever been present

◯ Pre-diabetes ◯ Diabetes ◯ Dyslipidaemia ◯ Hypertension ◯ Obesity

CVD: ◯ Stroke ◯ IHD ◯ PVD ◯ Significant family history

Other medical illnesses (please list): _____

_____

Has patient previously seen a cardiologist?: ◯ No ◯ Yes

Psychiatric diagnoses

List current and any recent differentials e.g. Schizophrenia; depression x1

Current: _____

Other/differentials: _____

_____

Medication list

List **all** psychiatric and medical regular medicines inc. dose and frequency.

Medical 1: _____

Medical 2: _____

Medical 3: _____

Medical 4: _____

Medical 5: _____

Medical 6: _____

Psychiatric 1: _____

Psychiatric 2: _____

Psychiatric 3: _____

Psychiatric 4: _____

Psychiatric 5: _____

Other, including Vitamins, complementary therapies, …

Please list: _____

_____

ccCHiP Contact details

Contact the ccCHiP Business manager on:
Phone 02 9767 6027 | **Fax** 02 9767 7107 | **Email** referrals@ccchip.clinic