Collaborative Centre for
Cardiometabolic Health
in Psychosis

Health
Sydney
Local Health District

EXTERNAL REFERRAL TO ccCHiP (ages: 16 to 18 years)

IMPORTANT! PLEASE READ:

A. This form is ONLY for use by SLHD Inpatient Child and Adolescent Services. For general adults, see the alternative form.

B. **ALL** data fields requested on this form are required for the referral to be accepted for triaging.

C. Acceptance of a referral for triaging is NOT a guarantee that an appointment will be offered.

Consent: the patient has 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

For patients <18 years, the parent(s) and/or guardian(s) have consented to the referral: ◯ Yes ◯ No

Patient details

Name: ______________________________

Birth sex: ◯ Female ◯ Male

DOB (DD-MM-YY): ______________________

Address: ____________________________

____

Phone: ______________________________

Email: ______________________________

Fax: ________________________________

Health system details

RPA MRN: ___________________________

CRGH MRN: __________________________

Community MRN: ______________________

Medicare #:__________________________

Medicare Ref:_______Expiry:_______________

Pension #: ___________________________

Is the patient registered with the National Diabetes Services Scheme (NDSS)?

◯ Yes ◯ No ◯ Unknown

Carer/Next of Kin/Guardian:

Patients <18 years must be accompanied by above

____

Relationship to patient:

____

Phone: ______________________________

Email: ______________________________

Referring to ccCHiP Clinic

Psychiatrists: Prof Tim Lambert; Dr Kathleen Smith; Dr Khadijah Shah Idil.

Cardiologists: Dr Vincent Chow; Dr Thomas Yeoh.

Endocrinologists: Dr Timothy Middleton; Dr Avinash Suryawanshi.

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Referrer details

◯ Tick if same as GP

Name: ______________________________

Practice address:

____

____

____

Phone: ______________________________

Provider No.: ______________________________

Referrer signature:

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:

Tick all that are relevant to **this** referral

◯ First visit

◯ Scheduled follow-up

◯ 12 months since last ccCHiP review

◯ Patient or carer request

◯ Opinion regarding cardiometabolic risk/s

◯ Weight in the overweight or obese range

◯ Dyslipidemia

◯ Hypertension

◯ Diabetes or pre-diabetes

◯ Other endocrinopathy

◯ Cardiological review

◯ Other medical problem

____

____

Interpreter services

Interpreter required: ◯ Yes ◯ No

If 'Yes', which language? ____________________

GP details

Name: ______________________________

Practice address:

____

____

____

Phone: ______________________________

Psychiatrist details

Name: ______________________________

Practice address/CMHC:

____

____

____

Care Coordinator details

Name: ______________________________

Clinical address (include team if applicable):

____

____

Phone: ______________________________

Email: ______________________________

Fax: ______________________________

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Patient medical history

Please tick any that have **ever** been present

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

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

Other medical illnesses (please list): ____________________

____

Significant Family history (please list): ____________________

____

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

Has patient previously seen an endocrinologist?: ◯ 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: ____________________

____

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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 cannot 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)

Please put 'ccCHiP' in the CC box of the path form.

- √ ◯ EUC
- √ ◯ FBC
- √ ◯ LFT
- √ ◯ TFT
- √ ◯ Serum Uric Acid
- √ ◯ BGL
- √ ◯ High sensitivity C-reactive protein
- √ ◯ ACR (Urine Albumin Creatinine Ratio)
- √ ◯ B12 (if receiving metformin)
- √ ◯ Clozapine/NDMC levels **(if on clozapine)**
- √ ◯ Lithium/Valproate levels **(if applicable)**
- √ ◯ 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: ______________________

ccCHiP Contact details

Contact the ccCHiP Clinic Liaison Manager on 0439 578 379
Phone 02 9767 6027 | **Fax** 02 9767 7107 | **Email** referrals@ccchip.clinic

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