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, dentalteam, 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; A/Prof. Anoop Sankaranarayanan; Dr Khadijah Shah Idil.

Cardiologists: Dr Vincent Chow; Dr Thomas Yeoh.

Endocrinologists: Dr Timothy Middleton; Dr Avinash Suryawanshi.

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: _____

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: _____

_____

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