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

IMPORTANT! PLEASE READ:

A. This form is ONLY for use by SLHD 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.

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

Covid Vaccination status: Has the patient received *at least two* doses of a Covid-19 vaccine?

◯ Yes ◯ No ◯ Unknown

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 at

◯ Concord

◯ RPA / Charles Perkins Centre

Psychiatrists: Prof Tim Lambert; Dr Yi Von Ooi; A/Prof Michael Tam.

Cardiologists: Dr Vincent Chow; Dr Thomas Yeoh.

Endocrinologist: Dr Timothy Middleton.

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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: ◯ No ◯ Yes

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 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 Request Form: You can find a downloadable copy of the ccCHiP Pathology Request Form at https://www.ccchip.clinic/static/pdfs/ccCHiP_Pathology_Form.pdf

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)
- ✓ Folate
- ✓ 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

*Bulk billed by Laverty and Douglass Hanly Moir

Date blood collection (DD-MM-YYYY): _____

Pathology lab used: _____

ccCHiP Contact details

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

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