



EXTERNAL REFERRAL TO ccCHiP (non-SLHD or GPs)

IMPORTANT! PLEASE READ:

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

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:

Relationship to patient:

If attending/transporting, contact details of carer:

Referring to ccCHiP Clinic at

- ☐ Concord
☐ RPA / Charles Perkins Centre

Psychiatrist: Prof Tim Lambert.

Cardiologists: Dr Vincent Chow; Dr Thomas Yeoh.

Endocrinologist: Dr Timothy Middleton.



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): _____

Relevant 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: _____

Psychiatric 1: _____

Medical 2: _____

Psychiatric 2: _____

Medical 3: _____

Psychiatric 3: _____

Medical 4: _____

Psychiatric 4: _____

Medical 5: _____

Psychiatric 5: _____

Medical 6: _____

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 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)

- | | |
|---|---|
| <input checked="" type="checkbox"/> EUC | <input checked="" type="checkbox"/> Total Cholesterol/Triglycerides/HDL/LDL |
| <input checked="" type="checkbox"/> FBC | <input checked="" type="checkbox"/> High sensitivity C-reactive protein |
| <input checked="" type="checkbox"/> LFT | <input checked="" type="checkbox"/> ACR (Urine Albumin Creatinine Ratio) |
| <input checked="" type="checkbox"/> TFT | <input checked="" type="checkbox"/> B12 (if receiving metformin) |
| <input checked="" type="checkbox"/> Serum Uric Acid | <input checked="" type="checkbox"/> Clozapine/NDMC levels (if on clozapine) |
| <input checked="" type="checkbox"/> BGL | <input checked="" type="checkbox"/> Lithium/Valproate levels if applicable |
| <input checked="" type="checkbox"/> Apolipoprotein B* | <input checked="" type="checkbox"/> HBA1c |
| <input checked="" type="checkbox"/> Calcium, Magnesium, Phosphate | |
- 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 Business manager on:

Phone 02 9767 6027 | **Fax** 02 9767 7107 | **Email** referrals@ccchip.clinic