SLHD INTERNAL REFERRAL TO ccCHiP CLINIC

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** data fields requested on this form are required for the referral to be accepted for triaging. As Covid restrictions lessen, patients will be seen in order as set by the multi-disciplinary triaging process.

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

◯ Community Health 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

_____

_____

Interpreter services

Interpreter required: ◯ Yes ◯ No

If 'Yes', which language? _____

GP details

Name: _____

Practice address:

_____

_____

_____

Phone: _____

Fax: _____

Care Coordinator details

Name: _____

Clinical address (include team if applicable):

_____

_____

Phone: _____

Email: _____

Fax: _____

Psychiatrist details

Name: _____

Practice address/CMHC:

_____

_____

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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): _____

_____

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: _____

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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