PLEASE NOTE: REFERRAL & PATHOLOGY RESULTS TO BE FAXED **10 DAYS** PRIOR TO THE DATE OF CLINIC VISIT

referral

FROM: COMMUNITY MENTAL HEALTH (CMH)/CARE CO-ORDINATOR DETAILS

Name of Co-ordinator: ______ Team: ______

CMH Address: ______ Phone: ______

Fax: ______

Is this patient under any other relevant care provider/Consultant? Mobile: ______

If YES please provide name: ______ *Care Provider/Consultant Contact Phone:* ______

PATIENT INFORMATION

Patient's Name: ______

Date of Birth: ______

Address: ______

Carer/Next of Kin/Guardian: ______

Relationship to Patient: ______

RPA MRN ______

CRGH MRN ______

Gender: ❑ MALE ❑ FEMALE

Mobile: ______

Mobile: ______

Is an interpreter required: ❑ YES ❑ NO

If so, please include language: ______

Community MRN ______

Medicare Number: ______

Medicare Reference No: ______

Medicare Expiry: / /

Pension No: ______

REFERAL INFORMATION

Date of referral:

Please tick below which clinic location you will be attending

For a complete assessment, please tick all the specialists under your preferred location

Dear

❑ **CONCORD CLINIC**	❑ **CPC RPA CLINIC**
❑ Prof Tim Lambert Medical Psychiatry	❑ Prof Tim Lambert Medical Psychiatry
❑ Dr Avinash Suryawanshi Endocrinology	❑ A/Prof Roger Chen Endocrinology
❑ Dr Vincent Chow Cardiology	❑ Dr Vincent Chow Cardiology

Reason for referral: ______

Who is referring this patient:

❑ GP *(12 months or indefinite)* or ❑ Staff Specialist *(3 months)*

Name of Referrer (or stamp): ______

Practice Address (or stamp): ______

______

Phone: ______ *Provider Number:

Signature of Provider:

LOCAL DOCTOR/GP

Name (or stamp): ______ Phone: ______

Practice Address: ______ Fax: ______

______

PATHOLOGY RESULTS [MANDATORY]

Date bloods collected: / /

Pathology lab collected: ❑ DHM ❑ Laverty

❑ MedLab ❑ Australian Clinical Labs

❑ Other (please list) ______

Please ensure that all the following **fasting** blood tests have been obtained and tick when complete:

❑ EUC ❑ FBC

❑ LFT ❑ CK

❑ TFT ❑ B12 & Folate

❑ Serum Uric Acid ❑ Fasting BGL

❑ Apolipoprotein B*

❑ Calcium, Magnesium, Phosphate

❑ Total Cholesterol/Triglycerides/HDL/LDL

❑ High sensitivity C-reactive protein

❑ ACR (Urine Albumin Creatinine Ratio) – if known diabetes

❑ HBA1c (if known diabetes - up to 4 per year, if diagnostic - 1 per year)

❑ Please add any other tests if relevant *(eg. Imaging, etc)*

Bulked billed by Laverty and Douglass Hanly Moir Pathology

PATIENT MEDICAL HISTORY *(please tick where appropriate)*

❑ Diabetes ....

❑ Hypertension......................................

❑ Dyslipidaemia....................................

❑ Obesity (BMI)....................................

❑ Cardiovascular Disease........................

❑ Stroke ❑ IHD ❑ PVD

❑ Significant family history

❑ Other – describe below. **Please include mental health diagnosis:**

______

______

______

LIST MEDICATIONS OR ATTACH

______

______

______

LOCATIONS:

Concord Hospital
Medical Centre, Level 2
Hospital Road
Concord NSW 2139
T | (02) 9767 7161
F | (02) 9767 7107
W | www.ccchip.clinic
E | referrals@ccchip.clinic

CPC RPA ccCHIP Clinic
The Charles Perkins Centre RPA Clinic
Johns Hopkins Drive
Camperdown NSW 2050
T | (02) 9767 6027
F | (02) 9767 7107
W | www.ccchip.clinic
E | referrals@ccchip.clinic

CLINIC USE ONLY

Date received by ccCHiP clinic:

/ /

Date patient seen by ccCHiP clinic:

/ /