REQUEST FOR CONSULTATION

GOLD COAST HOSPITAL AND HEALTH SERVICE

**HEART FAILURE SERVICE CLINIC**

**CHRONIC DISEASE WELLNESS PROGRAM**

Specialising in multidisciplinary care for the patients with complex care needs; assisting clients with cardiovascular disease return to optimal health and an active lifestyle aimed at reducing the risk of further cardiac events.

Supporting Team Care Arrangements (without utilising Medicare items)

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| **SEND TO**: Professor Rohan Jayasinghe  Central Intake Unit  Fax: 1300 668 536 **OR** Phone: 1300 668 936  **Secure transmission service via Medical Objects or**  **Healthlink to**  **QHEALTH,GOLD COAST HEALTH Adult Community Health Central Intake Unit** | **FROM**  **Doctors Name:**  **Practice Name:**  **Practice Address:**  **Phone:**  **Fax:**  **Email:**  **Provider Number:** |

**This service is for patients/clients 18 years and older who have a diagnosis of heart failure confirmed by a cardiologist. Heart failure diagnoses may include: Systolic dysfunction, diastolic heart failure, right heart failure.**

Please refer patients who have not been assessed by a Cardiologist to either private Cardiologists where available or to Cardiology Specialist Outpatients Department using the template available on www.healthygc.com.au

Dear Professor Jayasinghe

**SECTION 1 Patient details**

**Patient Full Name:**

**DOB:**

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| **Gender:**  **Address:**  **Home Ph**:  **Mobile Ph:**  **Medicare Number\*:**  (\*Medicare ineligible patients will incur a consultation fee) | **Next of Kin/Alternative Contact:**  **Next of Kin/Alternative Contact Ph:**  **Does patient identify as Aboriginal and/or Torres Strait**  **Islander:**  **Interpreter required:**  **If yes, specify language:** |
| **SECTION 2 Reason for referral and additional clinical information** | |

What is the reason for this referral:

Please provide provisional diagnosis (if available):

Please include any symptoms and date of onset (if known):

**Paste or type relevant history, clinical examination findings and treatment to date if required**

**SECTION 3 Mandatory clinical information**

Does this patient have a confirmed diagnoses of Heart Failure:

If yes, please specify type known:

When was the diagnosis made:

Has a Team Care Arrangement been completed:

If yes, attach GPMP/TCA

**SECTION 4 Investigations**

Please indicate whether the following pre-requisite investigations have been undertaken in order for this referral to be processed and attach the results.

**FBC, lipids, E/LFT, glucose within 3 months:**

**A recent ECG (if available):**

**A recent chest x/r report (if available):**

In addition, in please also attach investigation results you consider to be relevant, including coronary angiography, myocardial perfusion scan, echocardiography and/or exercise stress test results

**SECTION 5 Social factors and impact on the patient**

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| Consider the impact on employment/education; activities of daily life; ability to care for others; personal safety/frailty;  other factors. **Please paste or type relevant information.** |

**SECTION 6 Medical history including co-morbidities and previous surgical interventions**

**Alcohol Status/History:**

**Smoking Status/History:**

**Medical History:**

**Comorbidities:**

**Previous Procedures:**

**Allergies/Adverse Reactions:**

**Current prescribed medications:**

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| **SMOs/VMOs in this Specialist Service** |

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| Professor Rohan Jayasinghe |  |  |