REQUEST FOR CONSULTATION

GOLD COAST HOSPITAL AND HEALTH SERVICE

**RESPIRATORY SERVICE CLINIC**

**CHRONIC DISEASE WELLNESS PROGRAM**

Specialising in Community based multidisciplinary care for Patients with complex care needs.

Supporting Team Care Arrangements (without utilising Medicare items) and COPD/Asthma Action Plans

|  |  |
| --- | --- |
| **SEND TO**: Dr Siva P Sivakumaran  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:** |

For Clinical enquiries, please call Central Intake Unit 1300 668 936 and request the "Clinical Nurse Consultant: Respiratory"

**This service is for patients 18 years and older with:**

A confirmed diagnosis of COPD (who requires intensive multidisciplinary care) or;

A confirmed diagnosis of chronic asthma

Before referring the patient, consider whether you have excluded:

Lung Cancer;

Interstitial lung disease;

Cardiac disease associated breathlessness;

Pulmonary arterial hypertension

Pulmonary embolism

If not, or if there are remaining concerns, please refer instead to the GCHHS specialist outpatient department using the templates available on ***[www.healthygc.com.au]***

Dear Dr Sivakumaran

**SECTION 1 Patient details**

**Patient Full Name:**

**DOB:**

|  |  |
| --- | --- |
| **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 the patient consult with a private Respiratory specialist:

If yes, please specify Consultant name ad details:

Has a Team Care Arrangement been completed:

If yes, specify and attach GPMP/TCA details

When was the patient diagnosed:

Can patient participate in allied health led exercise program:

Do you have any concern regarding this patient participating in a graded exercise program:

Are there restrictions to consider during exercise:

If yes, please specify restrictions to consider:

**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.

**Spirometry (pre and post SABA):**

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

**Chest X-Ray report:**

In addition, please also attach investigation results you consider to be relevant, including chest CT scan, echocardiogram, ECG

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

|  |
| --- |
| 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:**

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

|  |
| --- |
| Dr Siva P Sivakumaran |