REQUEST FOR CONSULTATION

GOLD COAST HOSPITAL AND HEALTH SERVICE

**PAEDIATRIC CLINIC**

Template for correspondence about patient with

**GENERAL PAEDIATRIC SURGERY AND PAEDIATRIC UROLOGY**

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| **SEND TO**: Professor Deborah Bailey (Clinical Director Paediatric Surgery)Outpatient Access and Scheduling CentreFax: 07 5687 4497  **OR** **Secure transmission service via Medical Objects or****Healthlink to****QHEALTH,GOLD COAST HEALTH Outpatients****Outpatient Bookings and Referrals** | **FROM** **Doctors Name:** **Practice Name:****Practice Address:****Phone:** **Fax:** **Email:** **Provider Number:** |

Dear Professor Bailey

**SECTION 1 Patient details**

**RE:**

**DOB:**

**AGE:**

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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:** |

Mother's name:

Father's name:

Primary Carer's Name:

What is their relationship to the child:

**Please explain to the patient's representative that a parent or guardian who can give consent have to accompany the child to their hospital appointment, unless they are under the care of Department of Child Safety.**

Are there any family court orders in place:

Is there a guardianship order under the Department of Child Safety:

Was the child born at Gold Coast University Hospital:

**SECTION 2 Reason for referral and additional clinical information**

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| What it 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 / Paediatric Concerns**

Does the child have pre-existing diagnoses:

If yes, please specify:

Please specify the child's weight:

BMI included:

If no, please enter:

Has a diagnosis of constipation been made:

If yes, consider commencement of aprerients (e.g. osmolax/movicol):

**SECTION 4 Investigations**

Please include any relevant results or imaging. Films or digital images are preferred if possible and should be brought to the hospital appointment.

**SECTION 5 Duration of referral**

Please indicate how long you would like your referral to remain valid:

☐ 12 months

☐ Indefinite

Indefinite referrals do not expire until the patient has been discharged by the hospital service. When referrals expire, there is an expectation that the referring GP or another GP will review the care of the patient. If the patient still requires specialist care, the GP will then have to request a referral continuation.

**SECTION 6 Social factors and impact on patient**

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

**SECTION 7 Medical history including co-morbidities and previous surgical interventions**

**Clinical History Details:**

**Co-morbidities:**

**Previous Procedures:**

**Allergies:**

**Current prescribed medications:**

**Immunisation**:

**Relevant family history (allergies, bleeding disorders):**

**SMOs/VMOs in Specialist Service**

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| Professor Deborah Bailey (Clinical Director) | Dr Nada Sudhakaran | Dr Richard Thompson |