REQUEST FOR CONSULTATION

GOLD COAST HOSPITAL AND HEALTH SERVICE

**UROLOGY CLINIC**

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| **SEND TO** Dr Chris Tracey (Director of Urology)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:**  |

Date:

Dear Dr Tracey

**SECTION 1 Patient details**

**Patient Full Name:**

**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:**  |

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

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| 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 Medical history including co-morbidities and previous surgical interventions**

**Alcohol status/history:**

**Smoking status/history:**

**Medical history:**

**Comorbidities:**

**Previous procedures:**

[**Allergies/adverse reactions**](RST)**:**

**Current prescribed medications:**

**SECTION 4 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 be required to submit a new referral for ongoing care.

**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 Investigations**

Please indicate whether the following pre-requisite investigations have been undertaken in order for this referral to be processed and attach the results. In addition, please also attach any investigation results you consider to be relevant.

**For renal tumours: USS and/or CT IVP:**

**For LUTS: Urine MCS and cytology:**

**For haematuria: FBC, Urine MCS and USS/CT-IVP:**

**For scrotal problems: USS of scrotum/testes:**

**For calculi: non-contrast CT KUB, urine MCS, ELFT, FBC:**

**For prostate: PSA, ELFT, FBC, urine MCS:**

**For UTI: Urine MCS and cytology, USS urinary tract:**

**SMOs/VMOs in this Specialist Service**

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| Dr Chris Tracey (Director) | Dr John Pisko | Dr Neil Smith |
| Dr Yang Sun |  |  |

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| **General information about referrals** |

Queensland Clinical Prioritisation Criteria (CPC) are available for this condition and specialty. These criteria can be viewed by visiting: <https://cpc.health.qld.gov.au/>

Referral Templates that outline clinical information and investigations required to safely refer your patient into Gold Coast Health can be accessed via: <https://www.healthygc.com.au/Health-Care-Professionals/Referral-Templates.aspx>