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| **Referrers Details:** |
| Date of Referral:  | Referrers Name (GP):  |
| Organisation:  | Phone Number:  |
| GP Signature:   | Nurse Practitioner Signature:  (\*GP signature required within 6 weeks of referral) |
| **Client Details:** |
| Name:  | DOB:  |
| Gender: | **[ ]** Male **[ ]** Female **[ ]** Other **[ ]** Not stated |
| Address: |
| Home Phone:  | Mobile:  |
| Do you identify as: **[ ]** Aboriginal **[ ]** Torres Strait Islander **[ ]** Neither  |
| Country of Birth: **[ ]** Australia **[ ]** Other (please state): **[ ]** Interpreter Required |
| IPC Referral criteria: Please ensure blood results are recent (done within < 2 months) |
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| **Chronic condition**  | **IPC Services requested**  | **Last reported observations and test results**  |
| Arthritis  |[ ]  Pain Score:  |
| Asthma  |[ ]  Spirometry:  FEV1:  |
| Cardiovascular Disease:  |[ ]  Pulse:  BP:  Cholesterol:Specialist involvement: |
| Chronic Obstructive Pulmonary Disease (COPD)  |[ ]  Spirometry:  FEV1: |
| Chronic Pain  |[ ]  Pain Score:  |
| Diabetes  |[ ]  HBA1C: Lipids: eGFR: Urine ACR:  |
| High Cholesterol  | ☐ | Cholesterol: |
| Hypertension  |[ ]  BP:  |
| Obesity  |[ ]  Weight: Height:   |
| Osteoporosis  |[ ]  Bone Density Results  |
| Other  |[ ]   |
|  |  |  |

  Additional Information:    |
| **Does the client have a GP Management plan: [ ]** Yes **[ ]** No **GPMP/ Healthy Summary / Blood results Attached**: **[ ]** Yes **[ ]** No **GPMP Review Date:**  **Chronic Disease(s):**  **EPC Details**: |
| **GP Exercise Clearance:** |
| **Lifestyle Modification Contraindications:**Absolute: IF ALL ITEMS ARE NOT CHECKED YOUR PATIENT IS NOT SUITABLE FOR EXERCISE **[ ]** No recent significant change in resting ECG, recent MI, unstable angina or uncontrolled arrhythmia **[ ]** No symptomatic severe aortic stenosis, uncontrolled symptomatic heart failure, myocarditis or pericarditis **[ ]** No suspected or known dissecting aneurysm, acute pulmonary embolus or infarction, acute systemic infection Relative: THESE ITEMS ARE DISCRETIONARY IF EXERCISE BENEFITS OUTWEIGH RISKS - COMMENT IF RELEVANT **[ ]** No uncontrolled hypertension (SBP>200mmHg, DBP>110mmHg), left main coronary stenosis, moderate stenotic heart disease **[ ]** No high-degree AV block, ventricular aneurysm, hypertrophic cardiomyopathy, significant arrhythmias, no electrolyte abnormalities, uncontrolled metabolic diseaseThe referrer recommends this client is suitable to participate in physical activity [ ] Yes [ ] NoComments: *If in doubt a specialist opinion may be necessary before participating in the program. Please note, the IPC Care Coordinator may refer back to the GP if any contraindications arise during the program.* |
| **In case of Emergency contact** |
| Name:  Phone: Relationship to client:**Client has documented permission, evidenced at clinic for contact to** **share information directly related to and appropriate to ongoing care: Yes** [ ]  **/ No** [ ]  **Evidence attached**  **Yes** [ ]  **/ No** [ ]  |
| **Client Consent** |
| FocusOne Health is a voluntary service, and all clients must consent to and be willing to engage in services. The Integrated Primary Care (IPC) service providers are required to collect personal information from you so we can contribute to the provision of quality care coordination and health care. In doing so, we would like your permission to contact you for telehealth support. |
| Please print name: |       | Signed: |  |
| Name of Legal Guardian (if signing on the client’s behalf): |       | Date: |       |

*Information contained in this referral form is private/confidential. If you are not the intended recipient, any use, disclosure or copying of this document is unauthorised under the Health Care Act 2008 and may attract a fine of up to $10 000. If you have received this document in error, please contact the referrer.*