Triple I (Hub)
General Practitioner Referral

GENERAL PRACTITIONER REFERRAL (must complete this section)		
PATIENT DETAILS		
Family name:	**Given Names:**	
Sex:	**Date of Birth:**	**Age:**
Address:		
Phone (H):	**Phone (W):**	**Phone (M):**
Email:		
Ethnicity / Aboriginal and Torres Strait Islander Status: **Interpreter Required:** ☐ Yes ☐ No (if yes, language spoken):		
Medicare card no: IRN: Expiry: NOTE: If Medicare ineligible, fees will apply. Contact Triple I for details.		
DVA Card Number: Card Type: NOTE: If DVA Card Holder, refer to DVA unless Hospital Avoidance category of client.		
Pension/Health Care Card No:	**Private Health Insurer:**	
Marital Status:	**Occupation:**	
Next of Kin Details: **Name:** **Relationship to Carer:** **Contact Number:** **Address:**		
REFERRING MEDICAL OFFICER'S DETAILS		
Doctor's Name:		
Phone:	**Fax:**	
Address:		
Email:		

Please fax to: 02 4621 8799 - Telephone: 1800 455 511

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Clinical Details

Relevant Medical History:

Current Medications:

Current Community Supports

- ☐ Case Management CCT
- ☐ Centre-based Day Care
- ☐ Community Nursing
- ☐ Community Transport
- ☐ ComPack's
- ☐ Home Care Package
- ☐ Meals on Wheels
- ☐ Mental Health
- ☐ Palliative Care
- ☐ TACP
- ☐ End of Life Care
- ☐ Other

ONLY COMPLETE RELEVANT SECTION FOR THE SERVICE YOU ARE REFERRING THE PATIENT TO

Referral for Aboriginal Chronic Care Program (ITC)

Mandatory Criteria:
Client is Aboriginal, has given verbal or written consent to participate in this program and his/her GP Management Plan is attached along with any relevant clinical history including medications.

Client has one or more of the following chronic disease(s):
- ☐ Cancer
- ☐ Cardiovascular disease
- ☐ Diabetes
- ☐ Renal disease
- ☐ Respiratory disease
- ☐ Environmental / personal risks to be aware of:

Outline of presenting problem or risk identified:	**Date of Service to Commence:**

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Referral for Aged Care and Rehabilitation Services

[For services not listed below, or for Commonwealth Home Support System referrals, refer via My Aged Care]

Service(s) requested:

District Wide:	Dementia and Delirium CNC	
Bankstown (for patients >65 years)**:**	Neuropsychology	Speech Pathology
Fairfield (for patients >18 years):	Neuropsychology Physiotherapy Social Worker	Occupational Therapy Speech Pathology
Liverpool (for patients >18 years):	Neuropsychology Physiotherapy Social Worker	Occupational Therapy Speech Pathology
Macarthur SpACT (for patients >65 years)	Speech Pathology Occupational Therapy (palliative care only)	Upper Limb Clinic
Macarthur PDS (for patients <65 years)	Occupational Therapy Physiotherapy	Speech Pathology

Southern Highlands: Please phone Triple I to discuss

Reason for referral to above services

Referral for Child and Family Health Nursing

Name of baby/child (under 5 years) the referral is related to:

Patient/child is known to CFHN: ☐ Yes ☐ No | **Able to attend a clinic:** ☐ Yes ☐ No

Service(s) requested:

☐ Breast Feeding ☐ Development (inc. ASQ) ☐ Feeding ☐ Parenting / Mothercraft
☐ Parental Concern ☐ Sleeping and settling ☐ Other

Outline of presenting problem and treatment details (eg. breastfeeding management, other referrals):

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Altered parameters for vital signs: Mandatory field please tick yes or N/A and if yes, please populate the altered parameters.

☐ Yes ☐ N/A

Resps ________________

BP ________________

O2 SATS ________________

Pulse ________________

Referral for My Care Partners (Integrated Care and Enablers (IC&E))

(Only complete these sections if you are making a My Care Partners referral)

IC&E Program requested: My Care Partners ☐ Yes ☐ No Planned Care for Better Health ☐ Yes ☐ No	**Criteria:** Is at risk of readmission to hospital within the next 12 months ☐ Yes ☐ No
Outline of presenting problem or risk identified:	**Date of Service to Commence:**

Harp Risk Profile
TOTAL SCORE: / 50
Level of Risk Score: ☐ Urgent 39 – 49 ☐ High 24 – 38 ☐ Medium 11 – 23 ☐ Low 1 – 10
Reason for referral if Risk Score is 11 or below:

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WORK HEALTH SAFETY – (MANDATORY FIELD TO FILL)

Safety or security concerns ☐ Yes ☐ No (if yes, provide details):
Domestic Violence ☐ Yes ☐ No ☐ Unknown
Current problems with alcohol and substance misuese ☐ Yes ☐ No ☐ Unknown
Animals of concern at home (if yes, request they be locked up prior to home visit) ☐ Yes ☐ No ☐ Unknown
Enviroment risks for staff (building works, weapons, poor access) ☐ Yes ☐ No ☐ Unknown
Behavioural Issues (aggression) ☐ Yes ☐ No ☐ Unknown
Safety Issues (medications etc.) ☐ Yes ☐ No ☐ Unknown
Known Infectious Disease (Hep A, B, C, TB, Chicken pox) ☐ Yes ☐ No ☐ Unknown
Known Multiresistant Organisms (MRSA, VRE, ESBL, MRGN) ☐ Yes ☐ No ☐ Unknown

Has the patient received or had been prescribed
Cytotoxic medications (Cancer, Arthritis, Psoriasis) ☐ Yes ☐ No ☐ Unknown

Client / family aware of referral and willing to be contacted: ☐ Yes ☐ No
Client consents to referral ☐ Yes ☐ No

Current Medications

Current Medications or Attach GPMP

Referral for Primary and Community Health Nursing Services

[all other referrals > 65years of age to be directed to My Aged Care (MAC) except patients in RACFs in High Level Care] * denotes a Medication Chart or Clinical Authority Form is required

HITH/Hospital Avoidance (> 16 years):	Anticoagulation*	IV Therapy*
	Palliative Care (all ages)	S/C Syringe Driver Medications*
Nursing Services (16-65 years):	Catheter Management*	Continence Assessment
	Drains*	Nurse Practitioner consult
	Wound Consult (ComWAT)	Wound Management
	Residential Aged Care Facilities	

Able to attend a clinic: ☐ Yes ☐ No | **Date of Service to Commence:**

Outline of presenting problem/treatment details:

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Triple I (Hub)

General Practitioner Referral

Health
South Western Sydney
Local Health District

Referral for Positive FOBT Direct Access Colonoscopy (DAC)

SPECIALIST BEING REFERRED TO:

Please circle/nominate a Specialist:

Liverpool Clinic:	**Campbelltown Clinic:**
☐ Dr Ken Koo (Coordinator)	☐ Dr Ian Turner (Coordinator)

*If another specialist has a shorter wait time, the patient could be contacted and offered an earlier appointment. A new referral is not required.

MEDICAL HISTORY:

Weight (kg):	Height (m):
Previous colonoscopy: Y / N	If YES - year of last colonoscopy:

CURRENT SYMPTOMS:

- ☐ Nil
- ☐ Iron deficiency anaemia
- ☐ Unexplained weight loss
- ☐ Rectal bleeding
- ☐ Unexplained abdominal pain
- ☐ Palpable or visible rectal/abdominal mass
- ☐ Other (specify) ___________________________

Please tick ALL items:	YES	NO
Cardiac disease (e.g. IHD, heart failure, pacemaker, valve disease, coronary stent)		
Chronic respiratory disease (e.g. COPD, poorly controlled asthma)		
Chronic kidney disease EGFR < 60 ml/min/1.73m^2		
Cirrhosis		
Diabetes not on insulin		
Diabetes on insulin		
Obstructive sleep apnoea		
Advanced malignancy		
Impaired mobility affecting independence with bowel preparation (e.g. CVA, Parkinson's)		
Previous history of difficulties with anaesthesia		
On anticoagulant (warfarin, apixaban, dabigatran, rivaroxaban)		
On antiplatelet other than aspirin (e.g. clopidogrel, prasugrel, ticagrelor, asasantin)		
Is the patient anaemic or iron deficient?		
Has the patient had a colonoscopy within the last 4 years?		
Previous history of difficult colonoscopy (e.g. incomplete colonoscopy, complication)		
Does patient require a specialist assessment for GI symptoms prior to colonoscopy?		
Does the patient have capacity to understand instructions of the bowel preparation and advice of the risks and benefits of a colonoscopy?		

Other issues - Please specify:

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For FOBT DAC Referrals please attach the following documents to this referral form

- ☐ **Patient Health Summary**
- ☐ **Positive FOBT result**
- ☐ **Recent blood tests – FBE, UEC, LFT, Iron studies**
- ☐ **Specialist Letters for relevant conditions**

Date:	**Doctor's signature:**