SWSPHN Covid-19 Monitor Project Referral Form

Enquiries: 4632 3000
Referrals to be sent via fax: +61 2 9475 0690

1. Please include a patient Health Summary along with your referral
2. Please Note: High-risk patients with significant Risk Factors / Co-Morbidities will be managed by SWSLHD. If you have a **high-risk patient**, you can refer them to the **SWSLHD Clinical Escalation Line (open 7 days a week, 8:30-5:00pm) on 0460 021 244**
3. Patients who are considered high risk include:
    - People aged 60 years and older
    - Pregnant women
    - Aboriginal, Torres Strait Islander and Pacific Islander people (from age 35 years and over)
    - People with obesity, diabetes, serious cardiovascular disease, chronic lung disease, severe chronic liver or kidney disease, active cancer or who are immunocompromised
    - Some people with a disability including those with a disability that affects their lungs, heart, or immune system
    - Residents of aged care and disability care facilities
    - People aged 18 years and older who are unvaccinated.

If the patient meets the criteria below, you may refer the patient to the SWSPHN Covid-19 Monitor Project.

Is the patient < 65 years old? ☐ **Age:**	**No High Risk Factors?** ☐	**Asymptomatic or / Mild Symptoms?** ☐ ☐

Referrals cannot be accepted without the Patient's, Parent or Guardian Signed Consent

PLEASE PRINT CLEARLY

GP Details

Date:	**GP Name:**	**Practice Name:**
Practice Suburb:	**GP Phone:**	
GP Email:		**GP Fax:**

Please send completed Referral Form to covid19@swsphn.com.au
For enquiries regarding the Referral Form, please email covid19@swsphn.com.au or call 4632 3000

Patient Details

Title:	**First Name:**	**Last Name:**
Mobile / Best Contact Number:	**Date of Birth:**	**Email:**

Male ☐ **Female** ☐ **Other** ☐ | **Aboriginal** ☐ **Torres Strait Islander** ☐ **Both** ☐ **Neither** ☐

Do you identify as someone from a culturally and/or linguistic diverse background?
No ☐ **Yes – Background:** ☐

Interpreter required: ☐ **Language:**	**Does the patient have difficulty with Hearing:**

If the patient lives with other people, is there anyone else in the household that is infected with Covid-19 and requires monitoring as well? (Optional / If known)
Yes ☐ (Please provide details):
No ☐

If the practice has iRAD installed, has the patient consented? (If yes, you may be able to access updated information in real-time. If the practice has iRAD, it is highly recommended for you to consent the patient at the time of referral)
Yes ☐
No ☐

Parent / Carer / Guardian Details

If the patient is under 18 years of age and has a Parent / Carer or Guardian or if the patient is over 18 years of age and needs a Carer / Guardian, please enter the following details:

Name:	**Relationship:**	**Phone:**

Emergency / Next of Kin (NOK) Contact Details – if different from above

Name:	**Relationship:**	**Phone:**

Timeline of Illness

Date of Symptom Onset:	**Date of positive result:**

Vaccination Status

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Vaccination Status: Not Vaccinated One Dose Two Doses Three Doses+ ☐ ☐ ☐ ☐	Name of Vaccine/s:	Date of last Vaccination:

Previous Covid-19 Infection (Optional / if known)

Has the patient previously been infected with COVID-19? ☐ Yes ☐ No Treatment received? Date of last infection

Baseline Observations (if patient has given these details via telehealth consult)

Oxygen Saturation:	Pulse Rate:	Respiration Rate:	Temperature:	Blood Pressure:

Covid-19 Symptoms

☐ Asymptomatic	☐ Delirium	☐ Abdominal Pain
☐ Fever	☐ Syncope	☐ Diarrhoea
☐ Cough	☐ Chest Pain	☐ Headache
☐ Shortness of Breath	☐ Vomiting	☐ Inability to maintain oral intake

If the patient has Other Symptoms not listed above, please describe below:

_____

Thank you for agreeing to contact _____

I have gained consent for this referral from the patient (parent / carer / guardian if acting on behalf of patient).

I request that this patient be allocated to the SWSPHN Covid-19 Monitor Project.

Patient / Parent / Carer / Guardian Section:

Patient Consent

☐ Referrers must confirm that they have read out the following information to the client and they understand and has given (informed) verbal consent:

- to the program as it has been described to you by your referrer
- to your information being shared between the service provider and the funding body South Western Sydney PHN (SWSPHN), in accordance with the Privacy Act 1988
- to being contacted by the allocated participating nurse who will be providing clinical care
- to being contacted by the service provider, SWSPHN or its representative to complete a client experience of service survey or undertake other evaluation activities

☐ Consumer, parent/carer or guardian consents to this referral and agrees to information about their COVID-19 status being recorded in their medical file and shared between the patient's regular GP, South Western Sydney PHN COVID-19 Central Intake to assist in the management of their health care and the Registered Nurse to whom they are referred.

☐ The consumer understands that SWSPHN will provide information that does not identify them, such as the types of service they receive, for the purpose of research including informing on-going projects, and data around long-COVID

Consent to Leave a Message (if patient, parent, carer or guardian are not able to be contacted):

Tick all that apply:

☐ Voicemail on Home and or Mobile Phone Number

☐ SMS Text Message on Mobile Phone Number, if listed above

☐ Email to email address, if listed above

☐ With the Emergency / Next of Kin (NOK) contact person, as listed above

OFFICE USE ONLY:

Date Referral Received:	**Received By:**