PLEASE NOTE: REFERRAL & PATHOLOGY RESULTS TO BE FAXED 10 DAYS PRIOR TO THE DATE OF CLINIC VISIT

Collaborative Centre for Cardiometabolic Health in Psychosis

NSW GOVERNMENT Health Sydney Local Health District

sleep clinic referral

FROM: COMMUNITY MENTAL HEALTH (CMH)/CARE CO-ORDINATOR DETAILS

Name of Co-ordinator: _____ Team: _____

CMH Address: _____ Phone: _____

_____ Fax: _____

Is this patient under any other relevant care provider/Consultant? Mobile: _____

If YES please provide name: _____ *Care Provider/Consultant Contact Phone:* _____

PATIENT INFORMATION

Patient's Name: _____ RPA MRN _____ Community MRN _____

Date of Birth: _____ CRGH MRN _____ Medicare Number: _____

Address: _____ Gender: ☐ MALE ☐ FEMALE

Mobile: _____ Medicare Reference No: _____

Carer/Next of Kin/Guardian: _____ Mobile: _____ Medicare Expiry: _____

Relationship to Patient: _____ Is an interpreter required: No

If so, please include language: _____

Pension No: _____

REFERAL INFORMATION

Date of referral: _____

Dear

ccCHiP Sleep and Circadian Disorders Clinic

☐ Prof Tim Lambert
Medical Psychiatry

☐ Prof Ron Grunstein
Sleep Specialist

I wish to refer the above mentioned patient to the ccCHiP Sleep and Circadian Disorders clinic.
For a complete assessment, please tick all the specialists above

Reason for referral: _____

Who is referring this patient:

☐ GP *(12 months or indefinite)* or ☐ Staff Specialist *(3 months)*

Name of Referrer (or stamp): _____

Practice Address (or stamp): _____

_____

Phone: _____ *Provider Number:

Signature of Provider:

LOCAL DOCTOR/GP

Name (or stamp): _____ Phone: _____

Practice Address: _____ Fax: _____

PATIENT MEDICAL HISTORY *(please tick where appropriate)*

☐ Diabetes ……..

☐ Hypertension……..

☐ Dyslipidaemia……

☐ Obesity (BMI)……

☐ Cardiovascular Disease……

☐ Stroke ☐ IHD ☐ PVD

☐ Significant family history

☐ Other – describe below. **Please include mental health diagnosis:**

LIST MEDICATIONS OR ATTACH

ADDITIONAL NOTES

LOCATION:

ccCHIP Sleep and Circadian Disorders Clinic
The Charles Perkins Centre
Johns Hopkins Drive
Camperdown NSW 2050
T | (02) 9767 6027
F | (02) 9767 7107
W | www.ccchip.clinic
E | referrals@ccchip.clinic

CLINIC USE ONLY

Date received by ccCHiP S&CD clinic:
/ /

Date patient seen by ccCHiP S&CD clinic:
/ /