

Any patients living in Western Australia with asthma and/or COPD can be referred to our fully bulk billed services.

Please complete all sections and attach all relevant patient documents including Asthma/COPD Action Plan and Patient Management Plan.

## Referral From

<b>Referral From</b>	
<b>Referral From Name:</b>	
<b>Provider Number:</b>	
<b>Phone:</b>	

Secure Messaging

Healthlink address ID: **waasthma**

Fax  
Post

(08) 9289 3601  
Respiratory Care WA  
36 Ord Street  
West Perth, WA 6005

## Patient Details

<b>Patient Details</b>	
<b>First name(s):</b>	
<b>Family name:</b>	
<b>Preferred name:</b>	
<b>Title:</b>	
<b>Date of birth:</b>	
<b>Gender:</b>	

<b>Address incl. Street, City, State.</b>			
<b>Mailing address (if different):</b>			
<b>Post code:</b>		<b>Email:</b>	
<b>Telephone no.</b>			
<b>Home phone:</b>		<b>Work phone:</b>	
<b>Mobile:</b>		<b>Fax</b>	

<b>Special needs:</b>			
<b>Is an interpreter required?</b>		<b>If yes, language/dialect:</b>	
<b>Other special needs:</b>			

<b>Medicare eligible:</b>			
<b>Medicare number:</b>		<b>Ref:</b>	
		<b>Expiry:</b>	

<b>Next of kin/Guardian</b>			
<b>Full name:</b>			
<b>Relationship:</b>			
<b>Phone:</b>			

**Patient is aware we will contact them to confirm appointment via email/SMS information provided on the referral.**

- Consent for email confirmation of appt times
- Consent for SMS confirmation of appt times
- Consent for both email/SMS confirmation of appt times

<b>Referral Details</b>	
<b>Is the referrer the usual GP for the patient?</b>	
<b>If no, name of usual GP:</b>	
<b>Contact number:</b>	
<b>Length of referral:</b>	
<b>Is this a renewed referral?</b>	
<b>Is the referrer the usual GP for the patient?</b>	

**Reason for referring:**

Adult Respiratory Hub (Includes lung function testing, Registered Nurse assessment/education, Specialist Review if necessary)

Children’s Respiratory Hub (Includes lung function testing, Registered Nurse assessment/education, Specialist Review if necessary)

Diagnosis:

- |  |   |
|--|---|
| <input type="checkbox"/> Suspected asthma    | <input type="checkbox"/> Confirmed asthma |
| <input type="checkbox"/> Suspected COPD      | <input type="checkbox"/> Confirmed COPD   |
| <input type="checkbox"/> Undiagnosed / Other |   |

Chronic Condition Management Plan (CCMP) initiated     YES                       NO                       Unsure                       N/A

If yes, has the CCMP been updated in the last 3 months?     YES                       NO                       Unsure

Asthma / COPD Action Plan initiated                               YES                       NO                       Unsure                       N/A

If yes, has Action Plan been updated in the last 3 months?     YES                       NO                       Unsure

\*\* Any recommendations for CCMP or Action Plan updates by a Respiratory Care WA Health Professional will be provided in the report for GP to review with the patient.  
\*\*Respiratory Care WA does not Medicare bill for this activity.

<b>Clinical Information</b>	
<b>Observations:</b>	
<b>Percentile, height &amp; weight:</b>	
<b>Current problem:</b>	
<b>Past history:</b>	

<b>Current medications:</b>	
<b>Allergies:</b>	
<b>Other clinical information:</b>	
<b>Family history:</b>	
<b>Social history:</b>	

<b>Additional Clinical Information</b>
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Has your patient utilised emergency / urgent care resources in the past 12 months?  YES  NO

If yes:

- 1-2
- 3-5
- 5+

Has your patient required antibiotics for treatment of respiratory complications in the past 12 months?  YES  NO

If yes:

- 1-2
- 3-5
- 5+

Has your patient required oral corticosteroids for treatment of their respiratory condition in the past 12 months?  YES  NO

If yes:

- 1-2
- 3-5
- 5+

<b>Other Relevant Clinical Information</b>