

RCWA Referral Form – For Health Professionals

Adult Respiratory Hub | Children's Respiratory Hub | Respiratory Digital Health Service

SECURE MESSAGING Healthlink ID: waasthma	FAX (08) 9289 3601	POST Respiratory Care WA 36 Ord Street, West Perth WA 6005
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Eligibility	People living in Western Australia with asthma and/or COPD. All services are bulk billed.
Who can refer	GPs and other health professionals. Self-referrals are not accepted.
To avoid delays	Complete every section and attach the patient's Asthma/COPD Action Plan, Chronic Condition Management Plan (CCMP) and discharge summary where relevant.

This is not an emergency service.

Medical emergency: call 000 or go to the nearest emergency department.

Urgent but not an emergency: contact the patient's GP or call Healthdirect on 1800 022 222 (24 hours, 7 days).

1 SERVICE REQUESTED	
☐ Adult Respiratory Hub	<i>Tick one option</i> ☐ Pulmonary function testing (PFT) and nurse education ☐ Nurse education only
☐ Children's Respiratory Hub	☐ PFT, nurse education and specialist review
☐ Respiratory Digital Health Service <i>Delivered by telehealth</i> Not eligible: • Oxygen dependency • Residents of Aged Care Residential Homes • Individuals receiving palliative care • Individuals receiving active radiation therapy or chemotherapy	<i>Tick one option</i> ☐ Supported Transition – recent hospital admission or ED presentation for asthma/COPD ☐ Ongoing Community Support – education, self-management, smoking cessation, pulmonary rehabilitation linkage ☐ GP Support – case discussion and clinical advice on managing this patient

2 REFERRER DETAILS				
Referrer name			Provider number	
Practice name and address				
Phone			Fax	
Usual GP for this patient?	☐ Yes ☐ No		Referral length	
If no, usual GP name			Usual GP phone	
Renewal of a previous referral?	☐ Yes ☐ No			

3 PATIENT DETAILS			
Title		Preferred name	
First name(s)		Family name	
Date of birth		Gender	
Residential address			
Postal address (if different)			
Postcode		Email	
Mobile		Home / work phone	
Medicare eligible?	☐ Yes ☐ No	Medicare number	
Medicare IRN (Ref)		Medicare expiry	
Interpreter required?	☐ Yes ☐ No	Language / dialect	
Other support needs			
Next of kin / guardian		Relationship	
Next of kin phone			
Appointment confirmation	The patient is aware Respiratory Care WA will contact them using the details above and consents to confirmation by: ☐ SMS ☐ Email ☐ Both SMS and email		

4 CLINICAL INFORMATION	
Diagnosis	☐ Suspected asthma ☐ Confirmed asthma ☐ Suspected COPD ☐ Confirmed COPD ☐ Undiagnosed / other (please specify): _____
Reason for referral / current problem	
Past medical history	
Current medications	

Allergies	
Recent observations	
Height and weight (children: include percentiles)	
Family history	
Social history (including smoking status)	

5 RESPIRATORY HISTORY *Tick one box per row*

In the past 12 months, how many times has the patient:	None	1–2	3–5	6 or more
Presented to an emergency department or urgent care service?	☐	☐	☐	☐
Required antibiotics for respiratory complications?	☐	☐	☐	☐
Required oral corticosteroids for their respiratory condition?	☐	☐	☐	☐

6 CARE PLANS

Plan	In place?	If yes, updated in the last 3 months?
Chronic Condition Management Plan (CCMP)	☐ Yes ☐ No ☐ Unsure ☐ N/A	☐ Yes ☐ No ☐ Unsure
Asthma / COPD Action Plan	☐ Yes ☐ No ☐ Unsure ☐ N/A	☐ Yes ☐ No ☐ Unsure

Any recommended updates to the CCMP or Action Plan will be included in our report for the GP to review with the patient. Respiratory Care WA does not bill Medicare for this activity.

7 OTHER RELEVANT CLINICAL INFORMATION

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8 ATTACHMENTS AND SIGN-OFF

Attachments included	☐ Asthma / COPD Action Plan ☐ CCMP ☐ Discharge summary ☐ Other: _____
Patient consent	☐ The patient has agreed to this referral.

Referrer signature		Date	
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