

Self-Referral Form

Respiratory Digital Health Service (telehealth)

All services are bulk billed. Respiratory Care WA welcomes people from all cultures and communities, including Aboriginal and Torres Strait Islander peoples.

Fields marked * must be completed. **Incomplete forms will be returned and may delay my referral.**

I can refer myself if	I live in Western Australia and a doctor has told me I have asthma and/or COPD (chronic obstructive pulmonary disease).
To refer myself, I confirm *	☐ I do not use oxygen at home ☐ I do not live in a residential aged care home ☐ I am not receiving palliative care ☐ I am not currently having radiation therapy or chemotherapy

This is not an emergency service.

If it is an emergency, call 000 or go to the nearest emergency department. If you need urgent medical advice, contact your GP or call Healthdirect on 1800 022 222 (available 24 hours a day, 7 days a week).

1. THE HELP I NEED

Tick one option only *

- ☐ I have recently been to hospital or the emergency department because of my asthma or COPD and would like support now that I am home.
Date I left hospital or the emergency department: ____ / ____ / ____
- ☐ I would like ongoing support to help manage my asthma or COPD. For example:
- learning more about my condition
 - using my inhalers correctly
 - quitting smoking or vaping
 - joining a pulmonary rehabilitation program.
- ☐ I would like Respiratory Care WA to talk with my GP and provide advice about my care.

2. ABOUT ME

First name *		Family name *	
Date of birth *		Mobile *	
Suburb *		Postcode *	
Email		Emergency contact phone	
Medicare card *	Number: _____ ☐ I do not have a Medicare card	Ref (IRN): _____ Expiry: ____ / ____	
Do you need an interpreter *	☐ No ☐ Yes — my preferred language is: _____		
Do you have a regular GP*	☐ Yes (Please complete below) ☐ No		
GP name		GP practice	

3. MY HEALTH

I have *	☐ Asthma ☐ COPD (Tick both if you have both)
What would you like help with? *	
What medicines do you take now, including inhalers?*	
Do you have any allergies?*	
My other health conditions	
Smoking and vaping *	☐ I have never smoked or vaped ☐ I used to smoke ☐ I smoke now ☐ I vape now

In the past 12 months, how many times have you done the following? * (Tick one box per row)

	None	1–2	3–5	6 or more
Gone to hospital, an emergency department or an urgent care clinic because of your breathing	☐	☐	☐	☐
Needed antibiotics for a chest infection	☐	☐	☐	☐
Needed steroid tablets (for example, prednisolone) for my breathing	☐	☐	☐	☐

My care plans *

Plan	I have one	Updated in the last 3 months
Asthma or COPD Action Plan	☐ Yes ☐ No ☐ Not sure	☐ Yes ☐ No ☐ Not sure
GP Chronic Condition Management Plan (GP care plan)	☐ Yes ☐ No ☐ Not sure	☐ Yes ☐ No ☐ Not sure

Any suggested changes to my plans will be sent to my GP to review with me.

4. MY CONSENT

I have attached	☐ Action Plan ☐ GP care plan ☐ Hospital discharge summary ☐ Other: _____		
My consent *	☐ I agree to this self-referral and for Respiratory Care WA to contact me and my GP about my care.		
My signature *		Date *	

SEND MY FORM

EMAIL referrals@respiratorycarewa.org.au	POST Respiratory Care WA 36 Ord Street, West Perth WA 6005	QUESTIONS? CALL 08 9289 3600
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