**THS Respiratory Clinic Referral Form**Clinic Location (please circle and fax to appropriate clinic)

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| **Clinic** | **Open hrs** | **Fax number** |
| Hobart | 8:00am - 3:30pm | **03 6173 0842** |
| Launceston | 8:30am - 4:00pm | **03 6173 0842** |
| Burnie / East Devonport | 8:30am – 3:30pm | **03 6173 0842** |

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|  | |  | | --- | | **PATIENT DETAILS**  (optional fields\*) | | \*THCI | | Patient Name: | | Previous Name: | | Medicare No: | | DOB: | | Gender: M  F | | Address: | | Phone (h): | | Mobile: | | Alternate Contact: | |  | |  | | --- | | Referrers Name: | | Provider No: | | Practice Address: | | Phone:  Fax: | | Usual GP if not referrer: | |  |   **Date of Referral:**  **Reason for Referral**:  Consideration of COVID-19  screening test |

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| **Referral Details:**  Pre-referral information available at: [Tasmanian HealthPathways](https://tasmania.healthpathways.org.au/LoginFiles/Landing.aspx?from=ed4f60e8cd1a424db6e20c2ec512814d&page=709101.htm) |
| **Refer to latest COVID-19 alert (faxstream)**  1)<https://www.coronavirus.tas.gov.au/resources>  2) Under ‘For health professionals >’  3) Click on ‘Primary Care Update’  If your patient meets the COVID-19 testing criteria, does the patient have:   |  |  | | --- | --- | | **A fever (or history of fever) OR acute respiratory infection?** | Yes  No |     **FOR PATIENTS WHO HAVE MODERATE-SEVERE ILLNESS AND REQUIRE HOSPITAL ASSESSMENT. PLEASE REFER TO YOUR LOCAL EMERGENCY DEPARTMENT AFTER RINGING THE ED MOIC**  **FOR PATIENTS WHO DO NOT MEET THE CURRENT TESTING CRITERA DO NOT REFER TO THE RESPIRATORY CLNIC FOR TESTING.** |
| **Signed**:       **Date**: |
| **Interpreter Required**: Yes  **Language**: |