**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:       |

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| 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**:       |