RESPIRATORY SERVICES REFERRAL FORM

BLACK SWAN HEALTH LTD

Incomplete referral form may result in processing delays and impact on the client's care coordination
Please sign and submit the completed form to info@blackswanhealth.com.au or fax to 9201 0033
Please refer to the Black Swan Health website for eligibility and exclusion criteria

BINDING MARGIN – NO WRITING

Date of referral: ___ / ___ / _____

1. CLIENT DETAILS

Title: _____ ☐ Male ☐ Female ☐ Other D.O.B.: ___ / ____ / _____ *client must be over 18 to be eligible

Last Name: _____ First name(s): _____

Access issues: _____

Address: _____ Suburb: _____ Postcode: _____

Mobile: _____ Home: _____ Email: _____

Emergency contact / Next of Kin name: _____ Phone: _____

Is the client of Aboriginal and/or Torres Strait Islander descent? ☐ Yes ☐ No

2. REFERRER DETAILS

☐ GP (Skip to Section 3 – GP details) ☐ Specialist

Referrer name: _____ Position: _____

Address: _____ Suburb: _____ Postcode: _____

Phone: _____ Fax: _____ Email: _____

3. GP DETAILS

GP's name: _____ GP Stamp:

GP's practice: _____

Address: _____

Suburb: _____ Postcode: _____

Phone: _____ Fax: _____ Email: _____

4. REFERRAL INFORMATION

Confirmed respiratory diagnosis (please tick one for eligibility to the Respiratory Services Program):

☐ Asthma
☐ COPD (newly diagnosed or mild COPD FEV1 60-80% predicted)
☐ COPD FEV $_1$% predicted <60% or multiple hospital admissions/exacerbations due to respiratory condition
☐ Bronchiectasis (not due to Cystic Fibrosis)
☐ Interstitial Lung Disease

Respiratory Physician (if different to referrer above): _____

Lung function (attached results preferable):

FEV $_1$ (L):	FEV $_1$ (% Pred):	FVC (L):

Black Swan Health Limited (ABN 64 169 929 677)
t: 08 9201 0044 **f:** 08 9201 0033 **e**: info@blackswanhealth.com.au
Corporate office: 137-151 Main Street, Osborne Park, WA 6017
Service locations: Osborne Park | Joondalup | Midland | Fremantle | Cockburn
www.blackswanhealth.com.au

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Client's current respiratory condition

☐ Oxygen Therapy Flow rate: _____ Hours per day: _____

☐ CPAP / BIPAP Details: _____

Other relevant medical condition(s):

☐ Arthritis	☐ Chronic Pain > 3mth	☐ Heart Disease	☐ Postural Hypotension
☐ Asthma	☐ Diabetes	☐ High Cholesterol	☐ Smoker
☐ Brain / Spinal Injury	☐ Epilepsy /Seizures	☐ Hypertension	☐ Surgery
☐ Cancer	☐ Fall / Poor Balance	☐ Neurological Disorder	☐ Vision Impairment
☐ Chronic Fatigue	☐ Fractures	☐ Osteoporosis	☐ Other: _____

Current treatment: _____

_____

Current Medications (or attach): _____

_____

Allergies: _____

Note:
- **Please attach the GP Management Plan and/or Team Care Arrangement if available and the number of sessions to be allocated to the pulmonary physiotherapist.**

5. CONSENT TO REFERRAL - *Please tick the boxes below. Black Swan Health is only able to accept this referral where the client / guardian has consented to the referral, either verbally or in writing*

☐ I consent to be referred to Black Swan Health

Client / guardian signature: _____ Date: ___ / ___ / _____

Print Name: _____

☐ My client has been assessed and meets the eligibility criteria for a referral to Black Swan Health

☐ I have obtained verbal consent from the client / legal guardian to refer and provide their personal health information to Black Swan Health for further assessment

Referrer's signature: _____ Date: ___ / ___ / _____

Print Name: _____

OFFICE USE ONLY – leave blank
Unique client number (Black Swan Health to generate): _____

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