MEDICAL PRACTITIONER REFERRAL FORM

get healthy Information & Coaching Service

Queensland Government

Fields marked with * are mandatory
Please send the completed form to the Get Healthy QLD Service by:
Email: contactqld@gethealthy.org.au or Fax: 1300 013 242.
For more information: **Call: 13HEALTH (13 43 25 84) or Visit: www.gethealthy.qld.gov.au**

Medical Practitioner Details (Please print or stamp)

Practice stamp

Name*

Profession/Speciality

Organisation/Hospital*

Postcode* **Phone Number***

Email*

Feedback Letters All feedback letters will be sent to the above email address.

If you require feedback letters via post, please provide your postal address:

Please tick if you do not wish to receive feedback letters ☐

Patient details (Please print or affix patient sticker)

Name*

Date of Birth* **Postcode***

Phone Number*

Email

Address

Is an Interpreter required?* No ☐ Yes ☐

Language

Alt. Phone Number

Aboriginal and / or Torres Strait Islander origin?*

No ☐
Yes, Aboriginal ☐
Yes, Torres Strait Islander ☐
Yes, both Aboriginal and Torres Strait Islander ☐

Is your patient pregnant?* No ☐ Yes ☐

Preferred call time: AM ☐ PM ☐

The Service will call your patient within 5 working days upon receipt of a completed referral. If a mobile phone number has been provided on this referral form, your patient will receive a welcome SMS ahead of this call.

Primary Reason for Referral (Please tick one)

☐ Weight Management ☐ Healthy Eating ☐ Alcohol Reduction
☐ Physical Activity ☐ Diabetes Prevention ☐ Alcohol Abstinence in Pregnancy

Current body measurements: (Optional)

Waist Circumference (cm) _____ Weight (kg) _____ Height (cm) _____

If pregnant: Pre-pregnancy weight (kg): _____ Gestational age (wks): _____

General Comments Please describe any health condition(s)/impairment which may have an impact on what the patient eats and drinks or their physical activity.

Disclaimer: By completing this form, your participant is consenting to this information being sent to the Get Healthy Information and Coaching Service, and consents for the Service to contact them.

Date Sent: _____

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Medical Safety Assessment (Please tick all that apply)

Please indicate if the patient is currently experiencing or has experienced any of the following:

- ☐ Uncontrolled Asthma
- ☐ Unstable angina / chest pain
- ☐ Unstable/uncontrolled COPD
- ☐ Decompensated heart failure
- ☐ Post surgery under 3 months
- ☐ Unexplained weight loss (> 5% in 6 months)
- ☐ Unstable Hypertension (resting BP of systolic >180 or diastolic >100)

I, the Medical Practitioner listed above, confirm that the patient is fit to participate in the Get Healthy Information and Coaching Service

☐ Yes, fit to participate ☐ No, not fit to participate

Signature Date

All patients are screened prior to enrolling with the service. If your patient discloses any new or worsening conditions and/or symptoms not listed above, they may be referred back for ongoing management. An updated Medical Safety Assessment may be required to assess their suitability to participate with the Get Healthy Service.

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