Government of **Western Australia**
Department of **Health**

healthy pc

Central Referral Service

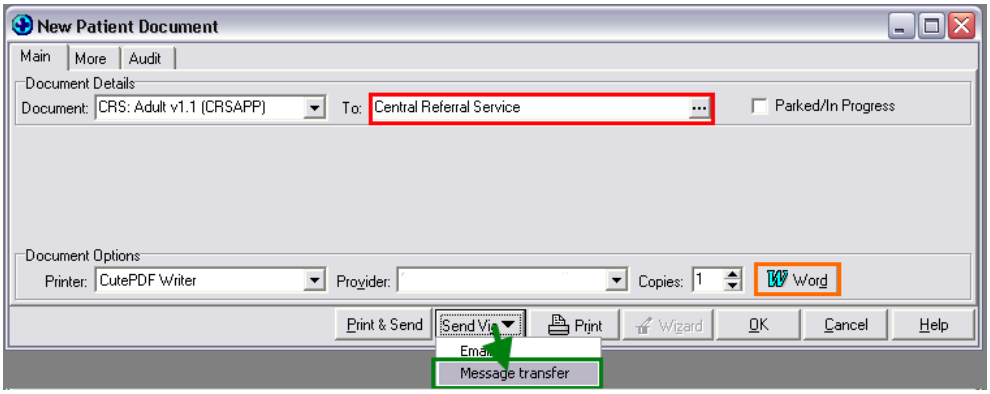
GUIDELINES FOR USING REFERRAL TEMPLATES IN MEDTECH 32

Delivering a **Healthy WA**

MEDTECH 32

General Adult Referral Template

1. Open **MT32**
   a. With the *correct patient record* open
2. Click *Other Documents*; Select *CRS Referrals*; Select *CRS: Adult v1-1*



3. Enter **Central referral service** in the *to* field (circled in red)
4. Click *Word* (circled in orange)
5. Tab through all of the following fields entering all of the relevant information for this referral.
   a. **Refer To** section

Referral To

(URGENT/IMMEDIATE REFERRALS ARE NOT SENT TO CRS, SEND DIRECTLY TO HOSPITAL)

Specialty:
Name of Specialist (if required):
Site:

   1. *Speciality* for the referral
   2. Name of the *Referring to* Doctor
   3. name of the *Hospital* or *Site* for the referral

   b. **Patient Details** section:

Patient Details

URMN Hospital No: (if known)

First Name(s): Anastasia
Family Name: Abbot
Preferred Name:
Previous Name (e.g. Maiden): Smith
Title: Miss
Marital Status: Never Married
Country of Birth: Australia
Birth Date: 04 May 1989
Gender: Female
ATSI Status: Neither Aboriginal nor Torres Strait Islander origin

Address:
345 Shell Terrace Waggrakine, WA
Post code: 6530
Telephone No:
Home: 08 9528 9369
Mobile: 0401536347

Mailing Address (if different):
345 Shell Terrace Waggrakine, WA 6530
Email:
Work: 08 5214 6523
Fax:

Special Needs:
Is an interpreter required? [ ] If Yes, language/Dialect:
Other Special needs:

Medicare Eligible: [ ] **Medicare No:** 4545 45454 5 **Ref:** 3 **Expiry:** 30 Dec 1899
DVA Card Number: N123456P **DVA Card Type:**
MVIT [ ] **Workers Compensation** [ ]

Next of Kin/Guardian
Name: Justin Abbot
Relationship: Partner **Phone:** 08 9310 0000

1. *URMN*
2. *Interpreter required*
3. *Which dialect*
4. *Other special needs*
5. *Medicare eligible*
6. *MVIT (motor Vehicle Insurance)*
7. *Worker's Compensation*

c. **Referral details**

Referral Details
Fill this box for Immediate Referrals only *(if the Patient must be seen by specialist within 7 days)*
Has the referral been discussed with Registrar or Consultant [ ] (essential for Urgent Cases)
If yes, the clinician's name:
Site: **Contact Number:**
Referral advice given:

1. Has the referral been *discussed with the registrar or consultant*?
2. *Name of Registrar*
3. *Contact Number*
4. *Referral advise given*

d. **Usual GP** details

Is the referrer the patient's usual GP? [ ]
If No, name of patient's usual GP:
Contact number:

1. Are you the *usual GP* for this patient
2. If not, enter *Name of Usual GP*
3. *Contact number*

e. **Referral Types** details

If the patient has been referred to this speciality for the same condition before, do they need to be referred to the same place again? [ ]
Is the patient suitable for a Telehealth consult? [ ]
Length of Referral: [ ] 3mth [ ] 12mth [ ] Indefinite
Is this a renewed referral? [ ]

Reason for referring:

1. Does this patient *need to be referred to the same place as before*
2. Are they suitable for a *telehealth consultation*
3. *Length of referral*
    1. *3 mths*
    2. *12 mths*
    3. *Indefinite*
4. *Renewed referral*
5. *Reason for referral*

f. **Clinical** details

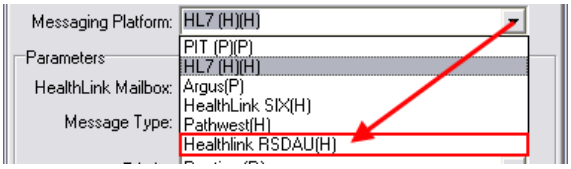
Clinical Information	
Observations (BMI, Height & Weight):	BMI: BMI :24.2 Height: Height :166 Weight: Weight :77
Current Problem:	? Pregnancy Asthma
Past History:	
Current Medications:	Ventolin CFC-free Inhaler 100 mcg/1 dose 200 doses Actonel 35 mg Once-a-Week Tablets 35 mg
Allergies:	26 Mar 2014 - - Patient is currently pregnant. Ensure that current medications and any new medications will not have adverse effects on the patient or foetus
Other:	
Family:	Depression;manic - MOTHER HAS MANIC EPISODES FREQUENTLY - Mother
Social History:	Current Smoker - EX Drinker -

Relevant Investigations and tests (Please attach)

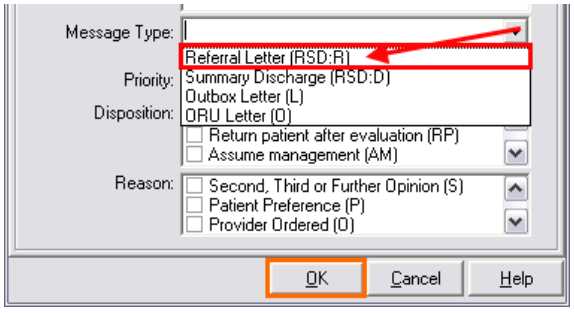
Pathology Provider: **Radiology Provider:**
Other Notes:
Doctor's Name: System Administrator **Provider Number:**
Designation: **Date:** 26 Nov 2014

1. *Other clinical information*
2. *Pathology provider*
3. *Radiology provider*
4. *Other notes*

6. *Save* and *close* this document
7. Click *send via*; Select *message transfer*
8. This will open the *Messaging Parameters Screen*
   a. Select the Messaging Platform (Healthlink RSDAU) (circled in red)



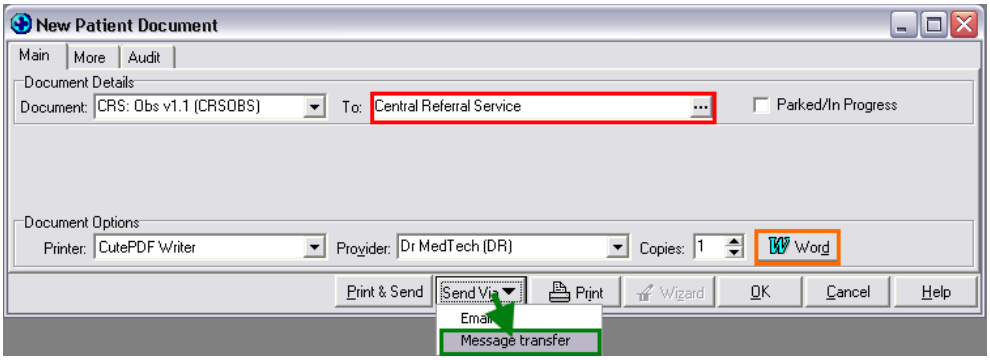
   b. Select the Message type: Referral Letter (RSD:R) (circled in red)



   c. Select the priority for the transmission: Routine (R)
   d. Click *OK* (circled in orange)
   e. A prompt will advise that *this document will be lodged*
   f. Click *OK*

Obstetrics & Gynaecology Referral Template

9. Open **MT32**
   a. With the *correct patient record* open
10. Click *Other Documents*; Select *CRS Referrals*; Select *CRS: Obs v1-1*



11. Enter **Central referral service** in the *to* field (circled in red)
12. Click *Word* (circled in orange)
13. Tab through all of the following fields entering all of the relevant information for this referral.
    a. **Service/s required** for the referral

Referral To

(URGENT/IMMEDIATE REFERRALS ARE NOT SENT TO CRS, SEND DIRECTLY TO HOSPITAL)

[ ] Antenatal Clinic	[ ] Gynaecology	[ ] Oncology
[ ] Ultrasound	[ ] Fertility	[ ] Colposcopy
[ ] CVS/Amino	[ ] Urogynaecology	[ ] Menopause
[ ] Genetic Services	Other	

Name of Specialist (if required):
Site:

1. *Antenatal Clinic*
2. *Gynaecology*
3. *Oncology*
4. *Ultrasound*
5. *Fertility*
6. *Colposcopy*
7. *CVS/Amino*
8. *Urogynaecology*
9. *Menopause*
10. *Genetic Services*
11. *Other*

    b. **Refer To** section
       1. Name of the *Referring to* Doctor
       2. name of the *Hospital* or *Site* for the referral
    c. **Patient Details** section:

Patient Details

URMN Hospital No: (if known)

First Name(s): Anastasia
Family Name: Abbot
Preferred Name:
Previous Name (e.g. Maiden): Smith
Title: Miss
Marital Status: Never Married
Country of Birth: Australia
Birth Date: 04 May 1989
Gender: Female
ATSI Status: Neither Aboriginal nor Torres Strait Islander origin

Address:
345 Shell Terrace Waggrakine, WA
Post code: 6530

Mailing Address (if different):
345 Shell Terrace Waggrakine, WA 6530
Email:

Telephone No:
Home: 08 9528 9369
Mobile: 0401536347

Work: 08 5214 6523
Fax:

Special Needs:
Is an interpreter required? [ ] If Yes, language/Dialect:
Other Special needs:

Medicare Eligible: [ ] **Medicare No:** 4545 45454 5 **Ref:** 3 **Expiry:** 30 Dec 1899
DVA Card Number: N123456P **DVA Card Type:**
MVIT [ ] **Workers Compensation** [ ]

Next of Kin/Guardian
Name: Justin Abbot
Relationship: Partner **Phone:** 08 9310 0000

1. *URMN*
2. *Interpreter required*
3. *Which dialect*
4. *Other special needs*
5. *Medicare eligible*
6. *MVIT (motor Vehicle Insurance)*
7. *Worker's Compensation*

d. **Referral details**

Referral Details

Fill this box for Immediate Referrals only *(if the Patient must be seen by specialist within 7 days)*
Has the referral been discussed with Registrar or Consultant [ ] (essential for Urgent Cases)
If yes, the clinician's name:
Site: **Contact Number:**
Referral advice given:

1. Has the referral been *discussed with the registrar or consultant*?
2. *Name of Registrar*
3. *Contact Number*
4. *Referral advise given*

e. **Usual GP** details

Is the referrer the patient's usual GP? [ ]
If No, name of patient's usual GP:
Contact number:

1. Are you the *usual GP* for this patient
2. If not, enter *Name of Usual GP*
3. *Contact number*

f. **Referral Types** details

If the patient has been referred to this speciality for the same condition before, do they need to be referred to the same place again? [ ]
Is the patient suitable for a Telehealth consult? [ ]
Length of Referral: [ ] 3mth [ ] 12mth [ ] Indefinite
Is this a renewed referral? [ ]

1. Does this patient *need to be referred to the same place as before*
2. Are they suitable for a *telehealth consultation*
3. *Length of referral*

1. *3 mths*
2. *12 mths*
3. *Indefinite*

4. *Renewed referral*
5. *Consent to shared care:* **DO/DO NOT**

If Obstetric Patient

We would like to share antenatal care with you, both before and after the first clinic visit (usually at 20 weeks).
I DO/I DO NOT wish to be involved in shared care

6. *Reason for referral*

g. **Clinical** details

Clinical Information		
Obstetric history:		
Gravida:	**EDD (by dates):** Date :29 Dec 2014	**EDD (by Scan):**
Parity:	**Multiple Pregnancy:**	**DCDA:** [ ]
LMP:	**Twins:** [ ]	**MCDA:** [ ]
	Other: [ ]	**MCMA:** [ ]
Observations (BMI. Height &	BMI: BMI :24.2	

1. *Multiple pregnancy types*
    1. *Twins*
    2. *Other*
    3. *DCDA*
    4. *MCDA*
    5. *MCMA*
2. *Other clinical information*

h. Relevant Antenatal Investigations and Tests to be copied to CRS

Relevant Antenatal Investigations and tests

Please include photocopies or arrange for copies of results of tests to be sent to the hospital. Nominate the test results you have arranged or will arrange: Please refer to CPAC guidelines for non obstetric referrals

[ ]	Full Blood Picture	[ ]	Pap (within 2 years)
[ ]	Blood Group and Antibody screen	[ ]	Pap (abnormal)
[ ]	Rubella IgG Serology	[ ]	Midstream Sterile Urine/MC&S
[ ]	Syphilis Serology	[ ]	Chlamydia Screening
[ ]	Hep B Surface Antigen	[ ]	Early dating ultrasound (if dates uncertain)
[ ]	Hep C Serology	[ ]	1st trimester screen (11-13 weeks) or maternal serum screening (15-17 weeks)
[ ]	HIV Serology		
[ ]	Vitamin D	[ ]	Fetal anatomy U/S (18-20 weeks)
[ ]	Haemoglobinopathy Screening	[ ]	Pelvic Ultrasound (non obstetric referrals)
[ ]	Other:	[ ]	Glucose Tolerance Test routine 24-28 weeks. *If high risk for GDM please do early OGTT*

1. *Full blood Picture*
2. *Pap (within 2 years)*
3. *Pap (abnormal)*
4. *Blood Group & antibody screen*
5. *Midstream Sterile Urine/MC&S*
6. *Rubella IgG Serology*
7. *Early dating ultrasound (if dates uncertain)*
8. *Chlamydia Screening*
9. *1st Trimester screen or Maternal Serum*
10. *Syphilis Serology*
11. *Fetal Anatomy U/S*
12. *Hep B Surface Antigen*

13. *Pelvic Ultrasound*
14. *HIV Serology*
15. *Glucose Tolerance Test*
16. *Vitamin D*
17. *Haemoglobinopathy*
18. *Other:*

i. Other Clinical details continued
   1. *Pathology provider*
   2. *Radiology provider*

j. Specialist service/s required before 20 weeks

Indicate Specialist service/s that you believe need to see this patient before 20 weeks, please state reason:

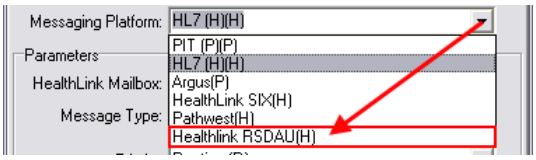
[ ] Genetic Services	[ ] Diabetes	[ ] Adolescent
[ ] Ultrasound	[ ] Obstetric Medicine	[ ] Drug and Alcohol
[ ] Maternal Fetal Medicine (high risk)	[ ] Dietician	[ ] Psychology
[ ] Social work	Other:	

Reason:

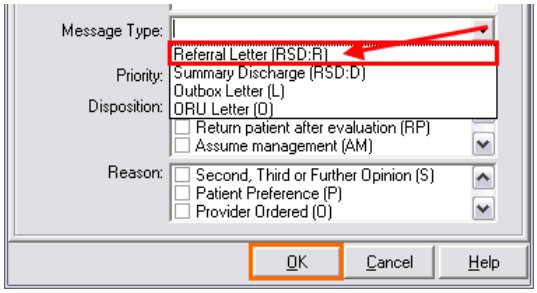
1. *Diabetes*
2. *Adolescent*
3. *Obstetric Medicine*
4. *Drug & Alcohol*
5. *Maternal Fetal Medicine*
6. *Dietician*
7. *Psychology*
8. *Social Work*
9. *Reason*

14. *Save* and *close* this document
15. Click *send via*; Select *message transfer*
16. This will open the *Messaging Parameters Screen*

g. Select the Messaging Platform (Healthlink RSDAU) (circled in red)



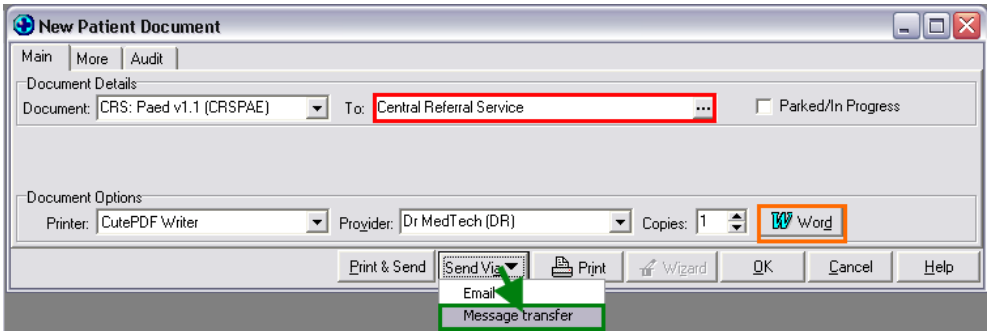
h. Select the Message type: Referral Letter (RSD:R) (circled in red)



i. Select the priority for the transmission: Routine (R)
j. Click *OK* (circled in orange)
k. A prompt will advise that *this document will be lodged*
L. Click *OK*

Paediatric Referral Template

17. Open **MT32**
    a. With the *correct patient record* open
18. Click *Other Documents*; Select *CRS Referrals*; Select *CRS: Paed v1-1*



19. Enter **Central referral service** in the *to* field (circled in red)
20. Click *Word* (circled in orange)
21. Tab through all of the following fields entering all of the relevant information for this referral.
    a. **Refer To** section

Referral To

(URGENT/IMMEDIATE REFERRALS ARE NOT SENT TO CRS, SEND DIRECTLY TO HOSPITAL)

Specialty:
Name of Specialist (if required):
Site:

    1. *Speciality* for the referral
    2. Name of the *Referring to* Doctor
    3. name of the *Hospital* or *Site* for the referral

    b. **Patient Details** section:

Patient Details

URMN Hospital No: (if known)

First Name(s): Anastasia
Family Name: Abbot
Preferred Name:
Previous Name (e.g. Maiden): Smith
Title: Miss
Marital Status: Never Married
Country of Birth: Australia
Birth Date: 04 May 1989
If born in WA, name of hospital:
Gender: Female
ATSI Status: Neither Aboriginal nor Torres Strait Islander origin

Address:
345 Shell Terrace Waggrakine, WA
Post code: 6530

Mailing Address (if different):
345 Shell Terrace Waggrakine, WA 6530
Email:

Telephone No:
Home: 08 9528 9369
Mobile: 0401536347

Work: 08 5214 6523
Fax:

Special Needs:
Is an interpreter required? [ ]
If Yes, language/Dialect:
Other Special needs:

Medicare Eligible: [ ] **Medicare No:** 4545 45454 5 **Ref:** 3 **Expiry:** 30 Dec 1899
DVA Card Number: N123456P
DVA Card Type:
MVIT [ ]
Workers Compensation [ ]

Next of Kin/Guardian
Name: Justin Abbot
Relationship: Partner
Phone: 08 9310 0000
Mother's name at time of Birth:

    1. *URMN*
    2. *Name of hospital,* if born in WA
    3. *Interpreter required*

4. *Which dialect*
5. *Other special needs*
6. *Medicare eligible*
7. *MVIT (motor Vehicle Insurance)*
8. *Worker's Compensation*
9. *Name of Mother at time of birth*

c. **Referral details**

Referral Details
Fill this box for Immediate Referrals only *(if the Patient must be seen by specialist within 7 days)*
Has the referral been discussed with Registrar or Consultant [ ] (essential for Urgent Cases)
If yes, the clinician's name:
Site: **Contact Number:**
Referral advice given:

1. Has the referral been *discussed with the registrar or consultant*?
2. *Name of Registrar*
3. *Contact Number*
4. *Referral advise given*

d. **Usual GP** details

Is the referrer the patient's usual GP? [ ]
If No, name of patient's usual GP:
Contact number:

1. Are you the *usual GP* for this patient
2. If not, enter *Name of Usual GP*
3. *Contact number*

e. **Referral Types** details

If the patient has been referred to this speciality for the same condition before, do they need to be referred to the same place again? [ ]
Is the patient suitable for a Telehealth consult? [ ]
Length of Referral: [ ] 3mth [ ] 12mth [ ] Indefinite
Is this a renewed referral? [ ]

Reason for referring:

1. Does this patient *need to be referred to the same place as before*
2. Are they suitable for a *telehealth consultation*
3. *Length of referral*
    1. *3 mths*
    2. *12 mths*
    3. *Indefinite*
4. *Renewed referral*
5. *Reason for referral*

f. **Clinical** details

Clinical Information	
Observations (Percentile, Height & Weight):	Percentile: Height: Height :166 Weight: Weight :77
Current Problem:	? Pregnancy Asthma
Past History:	
Current Medications:	Ventolin CFC-free Inhaler 100 mcg/1 dose 200 doses Actonel 35 mg Once-a-Week Tablets 35 mg
Allergies:	26 Mar 2014 - - Patient is currently pregnant. Ensure that current medications and any new medications will not have adverse effects on the patient or foetus
Other:	
Family:	Depression;manic - MOTHER HAS MANIC EPISODES FREQUENTLY - Mother
Social History:	Current Smoker - EX Drinker -

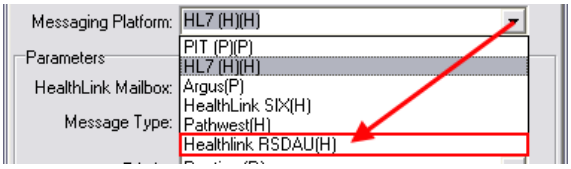
Relevant Investigations and tests (Please attach)

Pathology Provider: **Radiology Provider:**

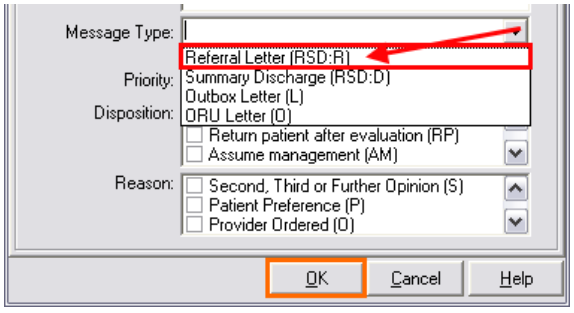
1. *Other clinical information*
2. *Pathology provider*
3. *Radiology provider*
4. *Other notes*

22. *Save* and *close* this document
23. Click *send via*; Select *message transfer*
24. This will open the *Messaging Parameters Screen*

m. Select the Messaging Platform (Healthlink RSDAU) (circled in red)



n. Select the Message type: Referral Letter (RSD:R) (circled in red)



o. Select the priority for the transmission: Routine (R)
p. Click *OK* (circled in orange)
q. A prompt will advise that *this document will be lodged*
r. Click *OK*

Delivering a **Healthy WA**