Interstitial Lung Disease Clinic Referral Form

STRICTLY CONFIDENTIAL

Attention to:

ILD Clinic

Dr Claire Thomson
Department of Thoracic Medicine
St. Vincent's Hospital
390 Victoria Street Darlinghurst
Phone: 02 8382 2175 Fax: 02 8382 3084
Email: Mignon.Lobo@svha.org.au

Referral Date: / /

Date received by SVH (SVH Use only): / /

Should you have any questions about this form or the referral process please contact 02 8382 2175.
Please complete all sections.

Referring Specialist
Name:
Phone:
Fax:
Email:
Phone:
Provider number:

General Practitioner Details
Name:
Phone:
Fax:
Email:
Phone:
Provider number:

Patient Details

Name:
Date of Birth: / /
Preferred name/s:
Sex: ☐ Male ☐ Female ☐ Indeterminate
Title: ☐ Mr ☐ Mrs ☐ Ms ☐ Miss
Medicare No:
Elective status: ☐ Public ☐ Private
Preferred language:

Address:
Mobile:
Phone: Work:
Email:
☐ DVA ☐ Work Cover Other ☐
Aboriginal/Torres Strait Islander: ☐ Yes ☐ No
Interpreter required? ☐ Yes ☐ No

Overview

Onset of symptoms:

Nature of symptoms

Examination Findings

Weight: …kgs **Height:** …m

Respiratory rate: …bpm **Oxygen Saturation**: …%

Smoking History

Smoking Status:

Current smoker ☐ Yes ☐ No

Ex-smoker ☐ Yes ☐ No If Yes, Date ceased: …Pack Year History date: …

Never smoked ☐ Yes ☐ No

Medical History Please complete all sections

Please note if any suspected or diagnosed:

Connective Tissue Disease ☐ Yes ☐ No …

Vasculitis ☐ Yes ☐ No …

Autoimmune Disease ☐ Yes ☐ No …

Any other relevant history:

…

…

Allergies:

Current Medication (list or attach print out)

Drug name	Strength	Dose / frequency / special

Test Results Please instruct patient to bring images with them to their appointment

☐ **HRCT** **Please arrange for this test to be done PRIOR to their appointment

☐ **Spirometry or Pulmonary Function Tests:**

FEV1: (% predicted) FVC: …(% predicted) Ratio: …

TLC: … DLCO: …

Exposure History:

Has the patient previously/currently been exposed to any of the following:

Radiotherapy: ☐ Yes ☐ No

Chemotherapy: ☐ Yes ☐ No

Amiodarone: ☐ Yes ☐ No

Methotrexate: ☐ Yes ☐ No

Birds: ☐ Yes ☐ No

Asbestos: ☐ Yes ☐ No

Silica: ☐ Yes ☐ No

Any other exposures considered relevant:

Signature of Referring Practitioner _____ **Date:** _____