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
Fax: 02 8382 2359
Email: Natasha.king@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 2330.
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: Interpreter required? Yes No

Address:
Mobile:
Phone: Work:
Email:
DVA Work Cover Other
Aboriginal/Torres Strait Islander: 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 answer if 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:**