HEAL HEALTHY EATING ACTIVITY & LIFESTYLE™ GP Referral Form

Surname: _____ First Name: _____

DOB: _____ Gender: M / F Aboriginal or Torres Strait Islander: Yes / No

Address: _____

Phone: (H) _____ (M) _____

Referral Criteria: ☐ Type II diabetes ☐ At risk of Type II diabetes
☐ BMI > 30 ☐ 2 or more CVD risk factors

HEAL™ Provider Details:

Patient has;

☐ **A new GP Management Plan** (MBS Item 721) **OR** ☐ **A review of an existing GP Management Plan** (MBS Item 732)

☐ **A referral form for Group Allied Health Services is also attached**

If available, I would also like to refer the patient for individual consultations under EITHER;

☐ **A Team Care Arrangement** (MBS Item 723) **OR** ☐ **A review of an existing Team Care Arrangement** (MBS Item 727)

Patient Contraindications - Please put a tick in the appropriate boxes:

☐ No recent significant changes in resting ECG, recent MI, unstable angina or uncontrolled hypertension

☐ No uncontrolled arrhythmia (atrial/ventricular), 3rd degree heart block without pacemaker, fixed rate pacemaker or ventricular ectopy

☐ No congestive heart failure, myocarditis or pericarditis

☐ No suspected or known aneurysm, intracardia thrombi, DVT or PE within the last 6 months

IF YOU HAVE NOT TICKED ALL OF THE ABOVE YOUR PATIENT IS NOT SUITABLE TO ATTEND THE PROGRAM

☐ No high blood pressure >140/90, unexplained chest pain, ischaemic type leg pains or SOB

☐ No abnormal electrolytes in the last 6 months, undiagnosed heart murmur or moderate to severe valvular heart disease

☐ No pregnancy or within 6 weeks of delivery

☐ No family history of MI, stroke or sudden death before the age of 55

IF YOU HAVE NOT TICKED ALL OF THE ABOVE YOUR PATIENT MAY NEED FURTHER INVESTIGATIONS (e.g. a stress test) BEFORE JOINING THE PROGRAM

GP & Patient Consent

- I have discussed what the exercise program involves, the benefits & potential risks/ discomforts (e.g. injury, heart problems).
- The contraindications form & any further investigations necessary have been completed.
- I agree, in consultation with the patient, that they are suitable for a low to moderate exercise assessment & exercise sessions.
- I have read 'Participating in the HEAL™ (below) and consent to this.

GP signature: _____

Patient signature: _____ Date: _____

Referring GP / Practice nurse:
(stamp contact details here)

Participating in the HEAL™ Program

- The program's goal is to assist GPs to improve the health of their patients
- Participation in the program is voluntary.
- Your personal information remains confidential. All data is stored in a secure location. Staff who have access to the data have all signed confidentiality agreements. Collated & de-identified data (i.e. personal details are removed) may also be provided to National Division Program, AGPN, RACGP & the Commonwealth Department of Health & Ageing for auditing, research, evaluation & quality assurance purposes. I hereby agree to my record being provided to the HEAL™ facilitator to assist in my health management.
- I understand that I have the right to withdraw consent at any time, without penalty, by requesting that my personal information be deleted.
- This consent is subject to: 1) the information stored being kept secure & confidential; 2) any information required for an audit, research &/or planning being used on an anonymous basis.
- I also understand that if I have any question relating to the security of my personal information I can ask my doctor, my HEAL™ facilitator or the HEAL™ National coordinator on 1300 933 397.