

# HEAL REFERRAL FORM for GPs & Health Professionals

Surname: \_\_\_\_\_ First name: \_\_\_\_\_

DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Gender: M / F Aboriginal and/or Torres Strait Islander: Yes / No

Postcode: \_\_\_\_\_ Phone: \_\_\_\_\_ Health Care/ Concession Card: Yes / No

**REFERRAL CRITERIA**

- Type II Diabetes
- At high risk of Type II Diabetes
- BMI  $\geq$  30kg/m<sup>2</sup>
- 2 or more cardiovascular disease risk factors

**PREFERRED OPTION**

- Aboriginal and Torres Strait Islander
- Teen
- 65+ years
- Culturally & Linguistically Diverse (CALD)  
Specific cultural group

**REFERRAL INFORMATION**

Referring provider: \_\_\_\_\_

Location of service: \_\_\_\_\_ Email: \_\_\_\_\_

Primary contact name: \_\_\_\_\_ Contact number: \_\_\_\_\_

Treatment aligns with GP Management Plan (MBS Item 721): Yes / No

Current team care arrangement (MBS Item 723): Yes / No

Recent Aboriginal and/or Torres Strait Islander Health Check (MBS Item 715): Yes / No

**CONTRAINDICATIONS****Absolute: IF ALL ITEMS ARE NOT CHECKED YOUR PATIENT IS NOT SUITABLE FOR EXERCISE**

- No recent significant change in resting ECG, recent MI, unstable angina or uncontrolled arrhythmia
- No symptomatic severe aortic stenosis, uncontrolled symptomatic heart failure, myocarditis or pericarditis
- No suspected or known dissecting aneurysm, acute pulmonary embolus or infarction, acute systemic infection

**Relative: THESE ITEMS ARE DISCRETIONARY IF EXERCISE BENEFITS OUTWEIGH RISKS**

- No severe hypertension (SBP $\geq$ 200mmHg, DBP $\geq$ 110mmHg), left main coronary stenosis, moderate stenotic heart disease
- No high degree AV block, ventricular aneurysm, hypertrophic cardiomyopathy, tachydysrhythmia or bradydysrhythmia
- No electrolyte abnormalities, uncontrolled metabolic disease

Comments:  
\_\_\_\_\_**GP & PATIENT CONSENT**

- As the GP, I have discussed what the exercise program involves, the benefits and potential risks/discomforts
- The contraindications section and further investigations necessary have been completed
- I agree, in conclusion with the patient, that they are suitable for a low to moderate exercise assessment and exercise sessions
- As the patient, I have read and understand the 'Participating in the HEAL program' (below)

GP signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Patient/Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**Participating in the HEAL Program**

- Participation in the program is voluntary
- Your personal information remains confidential and all data collected is stored in a secure location. Staff who have access to this data have signed confidentiality agreements. Collated & de-identified data (where all of your personal details have been removed) may be provided to the Commonwealth Department of Health & Ageing and may be used for the purposes of auditing, research, evaluation & quality assurance.
- 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 1300 179 765.