



## WESTERN AUSTRALIAN ACUTE RHEUMATIC FEVER AND RHEUMATIC HEART DISEASE REGISTER REFERRAL FORM

Office use only	Date of Receipt:    /    /	
	Register ID	

### SECTION 1: CASE DETAILS

Surname: .....

Other names: .....

Street address: .....

Suburb/town: ..... Postcode: .....

Telephone:    H: (    )                      W: (    )                      Mobile: .....

Date of birth:    /    /                      Age: .....                      Sex:     male     female

If case under 16 years of age, name of parent/guardian: .....

Aboriginal or Torres Strait Islander origin?     yes             no

### SECTION 2: BASIS OF REFERRAL

What signs and symptoms of acute rheumatic fever (ARF) or rheumatic heart disease (RHD) does this patient have now?

.....

.....

.....

**AND** Is there a recorded history of previous episodes of ARF?     yes     no     unknown

**Which care plan category will this patient have?**     LOW     MEDIUM     HIGH RISK

See the National Guidelines on [www.public.health.wa.gov.au/3/593/3/rheumatic\\_fever\\_acute.pm](http://www.public.health.wa.gov.au/3/593/3/rheumatic_fever_acute.pm)

Specialist doctor                      Has the patient been referred to a physician or cardiologist?     yes     no

If yes, name of specialist: .....

**ECHOCARDIOGRAM**                      **Please attach report from recent echocardiogram**

Hospitalised :                       yes     no     unknown

Hospital: .....                      Date of hospitalisation:    \_\_\_/\_\_\_/\_\_\_

### SECTION 3: REFERRING DOCTOR DETAILS

Name: .....

Address: .....

Telephone: .....                      Facsimile: .....

Signature: .....                      Date of referral:    \_\_\_/\_\_\_/\_\_\_

**Please return referral to the RHD REGISTER by secure fax (08) 9192 5397**