Support Services Referral Form

Gladstone Region Aboriginal and Islander Community Controlled Health Service Ltd (GRAICCHS) t/a **Nhulundu Health Service**
Phone: **4979 0992** Facsimile: **4979 0967**

NHULUNDU HEALTH SERVICE

To be eligible for the service, Aboriginal and Torres Strait Islander patients must be enrolled for chronic disease management in a general practice or an Aboriginal Community Controlled Health Organisation (ACCHO). **A new referral is required for each new service requested.** However, patients are only required to consent once.

PRACTICE DETAILS			
Practice/ACCHO Name:			
Practice/ACCHO Address:			
Doctor's Email:			
Phone Number:			
Fax Number:			
Referring GP:			
PATIENT DETAILS			
Name:			
Gender:	Male ❑ Female ❑ Intersex/Other ❑ Not stated ❑		
Residential Address:			
Postal Address:			
Date of Birth:	/ /	**Medicare Number #:**	/ *Exp:*
Phone Numbers:	*Home:*		*Mobile:*
Next of Kin or Support Person	*(Name & phone):*		
Health Care Card:	❑ YES ❑ NO	**Pension Card:**	❑ YES ❑ NO
DVA:	❑ YES ❑ NO	**Private Health Insurance:**	❑ YES ❑ NO
Smoking Status:	❑ YES ❑ NO	**Willing to engage in Telehealth?**	❑ YES ❑ NO

PROGRAM ELIGIBILITY	
Does the patient identify as Aboriginal and/or Torres Strait Islander? ❑ Aboriginal ❑ Torres Strait Islander ❑ Aboriginal and Torres Strait Islander	**Patient must be Aboriginal and/or Torres Strait Islander to be eligible**
Does the patient have a current GPMP and/or TCA (<12months old) ❑ YES ❑ NO	**Patient must have a GPMP and/or TCA in place to be eligible**
Please list the patient's Chronic Condition/s ***(NB: Private dental services are not covered)*** ❑ CANCER ❑ CARDIOVASCULAR DISEASE ❑ CHRONIC KIDNEY DISEASE ❑ CHRONIC MENTAL HEALTH ❑ CHRONIC RESPIRATORY DISEASE ❑ DIABETES ❑ Other Chronic Disease (List)	**Patient must have a chronic condition to be eligible**

*****Please detail all Support Services required, including Specialist Appointments, over Page *****

Billing Date: ..... GP Signature: .....

To be eligible for this Service the patient must have a current GP Management Plan and/or Team Care arrangement. Please confirm – attach billing confirmation (e.g., screen shot) (MBS 721 or MBS 723).

SUPPORT SERVICES REQUIRED AS PER CARE PLAN		
	Select	COMMENTS
Assisted breathing equipment	❑	
Blood sugar/monitoring equipment	❑	
Dose administration aids	❑	
Medical footwear (prescribed and fitted by a podiatrist)	❑	
Mobility aids or shower chairs	❑	
Spectacles (if not eligible for MASS - SSS)	❑	
Other:	❑	
	❑	
	❑	
	❑	
	❑	

If travel is required, has PTSS been organised? *If so, please attach details to this referral.*

❑ YES ❑ NO

Please note: Transport assistance will be determined by available funding

Does the patient require consultation fees to be covered by this fund?
If so, please include details in each appointment box below. Leave blank if not applicable.

❑ YES ❑ NO

Appointment 1 Details (if applicable)	
Discipline (either medical specialist or allied health):	
Organisation Name:	
Phone number:	
Is the appointment booked?:	❑ YES ❑ NO
Date/Time:	
Level of urgency:	❑ Urgent ❑ High ❑ Moderate ❑ Low

Appointment 2 Details (if applicable)	
Discipline (either medical specialist or allied health):	
Organisation Name:	
Phone number:	
Is the appointment booked?:	❑ YES ❑ NO
Date/Time:	
Level of urgency:	❑ Urgent ❑ High ❑ Moderate ❑ Low

Appointment 3 Details (if applicable)	
Discipline (either medical specialist or allied health):	
Organisation Name:	
Phone number:	
Is the appointment booked?	❑ YES ❑ NO
Date/Time:	
Level of urgency:	❑ Urgent ❑ High ❑ Moderate ❑ Low

Appointment 4 Details (if applicable)	
Discipline (either medical specialist or allied health):	
Organisation Name:	
Phone number:	
Is the appointment booked?	❑ YES ❑ NO
Date/Time:	
Level of urgency:	❑ Urgent ❑ High ❑ Moderate ❑ Low

Reasons these Support Services are required	
To address risk factors, such as a waiting period for a service longer than is clinically appropriate	❑
To reduce the likelihood of a hospital admission	❑
To reduce the patient's length of stay in hospital	❑
As services/equipment is not available through other funding sources	❑
To ensure access to a clinical service that would not be accessible because of the cost of a local transport service	❑

PATIENT CONSENT

My GP/Nurse/Health Worker has told me about Nhulundu Health Service and I want to participate.
I understand what I have been told and any questions I have had have been answered.
I understand that services (Service providers including my GPs and/or Aboriginal Medical Service staff, Specialists, Hospitals, Allied Health Workers) might have to share my information for care planning and to assess my eligibility for chronic care services. I know that wherever possible you will ask for my verbal consent to share information with other services before doing so.
I know that I can withdraw this consent at any time. To withdraw my consent, I must send a written note to my Care Link worker. The withdrawal will be valid as soon as the Worker gets my note, but will not apply to information that has been shared since my initial consent.
I agree that some information about me (but not my name) will be kept and used so that you can improve the way care is provided to Aboriginal and Torres Strait Islander People.

Patient name and signature:	**Name:** Signature: --- **Date:** ___/___/_____

AUTHORISATION

I have discussed the proposed referral to Nhulundu Health Service with the patient and am satisfied that the patient understands and is able to provide informed consent to this.

Consent explained and referral authorised by:	**Name:** Signature: --- Provider Number: _____ **Date:** ___/___/_____

DISCLAIMER: *Approval of the Support Services requested will be on a priority basis and contingent on staff capacity and available funding.*

Please FAX the signed Referral to: (07) 4979 0967

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Patient Copy – Please give to patient once Consent is signed

PATIENT CHARTER - Nhulundu Health Service

As a patient accessing *Nhulundu Health Service* **you have the right to**;

- access services that meet your health care needs
- receive safe and high-quality health services, provided with professional care, skill and competence
- receive open, timely and appropriate communication about your health care in a manner you can understand
- join in making decisions and choices about your care
- assume that the care provided will be respectful of you and your culture, beliefs and personal needs and requirements
- assume that your personal privacy is maintained and proper handling of your personal health and other information is assured
- comment on or complain about your care and have your concerns investigated and responded to.

In return you have the responsibility to:

- advise us of any changes to your contact details
- keep your appointments, or notify us if you are unable to attend
- provide accurate information about your health and anything else that may have an impact on your care
- be as open and honest as you can, and ask for more information if you do not understand
- ask questions so you can learn about your condition and your care options before giving your consent to any treatment
- discuss your concerns and decisions with your health care provider
- treat all staff and others with respect and dignity
- accept that your health information may be shared with appropriate other health care providers and other agencies as authorised by law
- ask for your recorded health information to be corrected if it is inaccurate
- respect the privacy and confidentiality of others

Please contact Nhulundu Health Service on (07) 4979 0992 if you have any questions or issues

NHULUNDU HEALTH SERVICE