



**General Practitioner Referral Form**

**Closing the Gap – Integrated Team Care (ITC) Program**

please fax completed form to **(07) 4131 0899**

OR send via Medical Objects to - ITC, BUNDABERG (BI4670000YJ)

Program Eligibility			
<b>Is this patient currently registered in the Indigenous Health Incentive?</b>	<input type="checkbox"/> Yes ( Must be registered to be eligible) <input type="checkbox"/> No		
<b>Has this patient had a health assessment (MBS 715) in the last 9-12 mths?</b>  <b>(needs to be completed to be eligible)</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Is a copy of the completed 715 Health Assessment attached?</b>  <b>Date of Assessment</b> _____/_____/20____	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>This patient has a current GP Management Plan and/or Team Care Arrangement</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Is a copy of the patient's GP Management Plan and/or Team Care Arrangement Attached? (Must be attached to be eligible)</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>The patient's chronic disease type/s Please write</b>			
<b>Reason for Referral ( tick one or more as appropriate) Please attach copies of Referrals to Specialist is required</b>	<input type="checkbox"/> Specialist - Name of specialist: _____		<input type="checkbox"/> Identify Discipline
	<input type="checkbox"/> Care Coordination		
	<input type="checkbox"/> Medical Aids <input type="checkbox"/> Dose Administration Aids (DAAs) <input type="checkbox"/> Assistive Breathing Equipment (Asthma Spacers; Nebulisers; Masks for Spacers and Nebulisers) <input type="checkbox"/> Continuous Positive Airways Pressure (CPAP) Machines <input type="checkbox"/> Accessories for CPAP Machines <input type="checkbox"/> Blood Sugar/Glucose Monitoring Equipment <input type="checkbox"/> Medical Footwear that is prescribed and fitted by a Podiatrist. <input type="checkbox"/> Other _____		
<b>Source of referral</b>	<input type="checkbox"/> <b>General practice</b>		
<b>Referring GP details</b>			
<b>Referring GP Name</b>			<b>Provider Number:</b>
<b>Practice name</b>			
<b>Patient details</b>			
<b>Surname:</b>	<b>First Name:</b>	<b>Date of Birth:</b>	<b>Gender:</b> <input type="checkbox"/> Male <input type="checkbox"/> Female
<b>Does this patient Identify as:</b>	<input type="checkbox"/> Aboriginal <input type="checkbox"/> Torres Strait Islander <input type="checkbox"/> Both <b>Medicare Number:</b> _____ Patient ID on card _____ Expiry Date ____/____/____		<b>DVA Card type &amp; No:</b> _____ <b>Health Care Card:</b> _____ Expiry Date ____/____/____
<b>Address:</b>	<div style="text-align: right;">Post Code:</div>		

<b>Phone number</b>	Home:	Work:	Mobile:
<b>The reason my patient requires Care Coordination services (tick 1 or more as appropriate)</b>	<input type="checkbox"/> is at significant risk of experiencing otherwise avoidable (lengthy and/or frequent) hospital admissions <input type="checkbox"/> is at risk of inappropriate use of services, such as hospital emergency presentations <input type="checkbox"/> May not be using community based services appropriately <input type="checkbox"/> needs help to overcome barriers to access services <input type="checkbox"/> requires more intensive care coordination than is currently able to be provided by general practice/Indigenous Health Service staff		
<b>Reason patient requires Supplementary Services (i.e. medical specialist/allied health/local transport services in accordance with the care plan (tick 1 or more as appropriate))</b>	<input type="checkbox"/> to address risk factors, such as a waiting period for a service longer than is clinically appropriate <input type="checkbox"/> to reduce the likelihood of a hospital admission <input type="checkbox"/> to reduce the patient's length of stay in hospital <input type="checkbox"/> as not available through other funding sources <input type="checkbox"/> to ensure access to a clinical service that would not be accessible because of the cost of a local transport service <input type="checkbox"/> Medical Item	<input type="checkbox"/> None required at present	
<b>Referral authorised by: GP name, signature and stamp</b>			
<b>Date</b>	___/___/___		

## Patient information and consent

My GP or Care Coordinator has discussed the ITC Program Fact Sheet with me. I understand what I have been told, any questions I had about the Program have been satisfactorily answered and I now want to participate.

- I understand that my participation is voluntary and that I have the right to withdraw from the Program at any time.
- I understand that a range of health and community service providers may collect, use and disclose my relevant personal information as part of my care.
- I understand that the personal information collected by these organisations will be maintained consistent with National Privacy Principles. It will remain confidential except when it is a legal requirement to disclose information; or where failure to disclose information would place me or another person at risk; or when my written consent has been obtained to release the information to a third party.
- I understand that statistical information (that will not identify me) will be collected and used to see how well the Program is working and help improve services for Aboriginal and Torres Strait Islander people.
- I understand that I am obliged to attend all scheduled appointments and that non-attendance will result in me being responsible for any associated fees and withdrawal of ITC and Specialist services.
- I understand that it is my responsibility to ensure that any medical aids supplied to me, are kept clean and maintained according to manufacturer's recommendations to ensure efficient operation.
- I will attend any follow up appointments as part of the monitoring and treatment plan regarding the use and effectiveness of the medical aide as requested by the Care Coordinator or provider.
- I understand that the PHN may process a Medicare claim for any Specialist service I may receive.
- **I understand that I am obliged to attend all scheduled appointments and that non-attendance will result in being responsible for any associated fees and will result in withdrawal of ITC support.**

<b>Patient Name and Signature</b>	
Print Name	
Signature	
Date	___/___/___

**If you require further information regarding the ITC program please contact:**

**Care Coordinator  
Bundaberg  
Ph. 07 4131 0800**

**Can we provide your Client with a copy of the GPMP and 715 Health Assessment?**

**Yes** \_\_\_\_

**No** \_\_\_\_