Integrated Team Care (ITC) General Practitioner Referral Form

Care Coordination and Supplementary Services

The ITC program provides assistance for Aboriginal and Torres Strait Islanders with chronic health problems who require help in coordinating their healthcare and/or require help in accessing services and medical aids not available through other funding sources, or not without lengthy delays.

Re-enrolment is required at the commencement of each calendar year for ongoing services.

Patient eligibility

Patient has a current 715 ATSI Health Check?  Yes ☐ No ☐

If yes, see Outreach Worker

Outreach Worker – if client identifies as Aboriginal and/or Torres Strait Islander, client is eligible for Outreach Worker Services

Aboriginal ☐ Torres Strait Islander ☐ Both ☐

Transport ☐ GP support ☐ Social support ☐

Patient has a current GP Management Plan and Team Care (721+723)?  Yes ☐

The patient has a significant chronic disease (tick one or more as appropriate)

Diabetes ☐ Cardiovascular disease ☐ Cancer ☐

Chronic respiratory disease ☐ Chronic renal disease ☐ Other chronic disease ☐

If other, please specify:

Referral date:

Referring GP details

Name: ____________________________________________

Phone number: ___________________________ Fax: ___________________________

Practice name: ____________________________________________

Practice street address: ____________________________________________

__________________________________________

Source of referral: General practice ☐ Community-Controlled Health Service ☐
Patient details

Surname: ___________________________ First name: ___________________________

Date of birth: ________________________

Gender: Male ☐ Female ☐ Other ☐

Residential address (including postcode): __________________________________________

________________________________________

Home phone number: __________________ Mobile number: ______________________

Care coordination

Patient requires care coordination: Yes ☐ No ☐

Level of assistance: Low ☐ Medium ☐ High ☐

Anticipated duration: Short (<6 mths) ☐ Medium (6-12 mths) ☐ Long term (>12 mths) ☐

Supplementary services

Patient requires funding assistance for:

☐ Allied health fee gap assistance ☐ Specialist fee gap assistance
☐ Radiology procedure fee gap assistance ☐ Transport subsidy (including parking fees and cab vouchers
☐ DAA (Dose administration aids including Webster Packing) – Arrange DMR ☐ CPAP equipment
☐ Nebuliser & other asthma-related equipment ☐ Orthotics & footwear
☐ Spectacles ☐ Glucometer & diabetes-related equipment
☐ Other (specify): Click here to enter text.

Note: services NOT covered include medication costs, operations or hospital stays.

Consider other funding sources, including:

- MAAS (Medical Aids Subsidy Scheme) – eg: continence aids
- NDSS (National Diabetes Subsidy Scheme) – eg: insulin needles
- QAS (Queensland Ambulance Service) – eg: clinic cars

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- Aged Care funding, including CAPS packages – eg: Vital Call, Aged Care transport
- QUMAX Funding – eg: DAA, glucometers, sphygmomameters, spacers, certain medications, testing lancets)
- Australian Disability Parking Permit
- QLD Government Taxi Subsidy Scheme
- Centrelink Essential Medical Equipment payment – electricity subsidy for running medical equipment such as CPAP, home dialysis, nebuliser etc

Referral authorised by GP (sign): ___________________________________________________________

Date: ______________________________________________________________________________

Consent form
(Mark box ☒ if consent is given)

☐ ITC CCSS PROGRAM CONSENT
My GP or Care Coordinator has discussed the CCSS 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.

☐ CASE CONFERENCE CONSENT
You, or one of the professionals involved in your care, can ask your care coordinator or GP to arrange a case conference at any time. Case conferences provide an opportunity for you and the people who provide medical and other services to meet and plan your future care.

The health care team including Care Coordinator will arrange a case conference upon enrolment of all new clients to ITC to discuss required services and care coordination.

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You are encouraged to attend case conferences but can choose not to or you may send someone on your behalf. A record will be kept in your medical notes and discussed with you and (if appropriate and with your agreement) your carer.

- I consent to my medical team arranging a case conference regarding my health management

☐ HOME MEDICATION REVIEW (HMR) CONSENT

- I consent to having a Home Medication Review (HMR).
- I regularly attend __________________________________________________________ pharmacy in ________________________________
- I consent to the release of my medical history and medication to the pharmacist.
- I understand the pharmacist will conduct the HMR and communicate to me information arising from the HMR.
- I consent to the release of my Medicare Number to the pharmacist for the pharmacist’s payment purposes.

Patient signature and consent: __________________________________________________________

Patient name: __________________________________________________________

Date: _________________________________________________________________________

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

Referring GP’s signature: __________________________________________________________

GP name: __________________________________________________________

Date of referral: __________________________________________________________________

Care Coordinator signature: _________________________________________________________

Name of Care Coordinator: __________________________________________________________

Date: __________________________________________________________________________

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Notes

¹Care Coordination Criteria
Client:
- is at significant risk of experiencing otherwise avoidable (lengthy and/or frequent) hospital admissions
- is at risk of inappropriate use of services, such as hospital emergency presentations
- is not using community based services appropriately or at all
- needs help to overcome barriers to access services
- is unable to manage a mix of multiple community-based services.

²Supplementary Services Criteria
- 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 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.

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