

General Practitioner Referral Form

Care Coordination and Supplementary Services

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 <input type="checkbox"/> Female <input type="checkbox"/> Intersex/Other <input type="checkbox"/> Not stated <input type="checkbox"/>			
Residential Address:				
Postal Address:				
Date of Birth:	/ /	Medicare No.	Ref:	Exp:
Phone Numbers:	Home:		Mobile:	
Next of Kin or Support Person	Name:		Phone:	
Health Care Card:	<input type="checkbox"/> YES <input type="checkbox"/> NO	Pension Card:	<input type="checkbox"/> YES <input type="checkbox"/> NO	
DVA:	<input type="checkbox"/> YES <input type="checkbox"/> NO	Private Health Insurance:	<input type="checkbox"/> YES <input type="checkbox"/> NO	
Smoking Status:	<input type="checkbox"/> YES <input type="checkbox"/> NO	Willing to engage in Telehealth?	<input type="checkbox"/> YES <input type="checkbox"/> NO	
PROGRAM ELIGIBILITY				
Does the patient identify as Aboriginal and/or Torres Strait Islander? <input type="checkbox"/> Aboriginal <input type="checkbox"/> Torres Strait Islander <input type="checkbox"/> 715 date: / / <input type="checkbox"/> Aboriginal and Torres Strait Islander			Patient must be Aboriginal and/or Torres Strait Islander to be eligible and have current 715 Health check	
Does the patient have a current GPMP(721) and TCA(723) <12months old <input type="checkbox"/> YES <input type="checkbox"/> NO			Patient must have a GPMP and TCA in place to be eligible	
Please list the patient's Chronic Condition/s (NB: Private dental services are not covered) <input type="checkbox"/> Cancer. <input type="checkbox"/> Chronic Respiratory Disease <input type="checkbox"/> Cardiovascular Disease. <input type="checkbox"/> Chronic Kidney Disease <input type="checkbox"/> Chronic Mental Health. <input type="checkbox"/> Diabetes. <input type="checkbox"/> Other Chronic Disease (please advise)			Patient must have a chronic condition to be eligible	
***Please detail all Support Services required, including Specialist Appointments, over Page ***				

Billing Date: GP Signature:



Gladstone Region Aboriginal and Islander Community
 Controlled Health Service Ltd ACN. 610 044 641
 27-29 Goondoon St, PO Box 5158 Gladstone Q 4680
 Phone. 07 4979 0992 | Fax. 07 4979 0967
 Email. reception@nhulundu.com.au
www.nhulundu.com.au

Integrated Team Care (ITC) Program

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

SUPPORT SERVICES REQUIRED AS PER CARE PLAN

Details	Select	Comments
Assisted breathing equipment	<input type="checkbox"/>	
Blood sugar/monitoring equipment	<input type="checkbox"/>	
Dose administration aids	<input type="checkbox"/>	
Medical footwear (prescribed and fitted by a podiatrist)	<input type="checkbox"/>	
Mobility aids or shower chairs	<input type="checkbox"/>	
Spectacles (if not eligible for MASS - SSS)	<input type="checkbox"/>	
Assistance to access Specialists	<input type="checkbox"/>	
Assistance to access Allied Health	<input type="checkbox"/>	
Other:	<input type="checkbox"/>	
	<input type="checkbox"/>	
	<input type="checkbox"/>	

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?:	<input type="checkbox"/> YES <input type="checkbox"/> NO
Date/Time:	
Level of urgency:	<input type="checkbox"/> Urgent <input type="checkbox"/> High <input type="checkbox"/> Moderate <input type="checkbox"/> Low

Appointment 2 Details (if applicable)

Discipline (either medical specialist or allied health):	
Organisation Name:	
Phone number:	
Is the appointment booked?:	<input type="checkbox"/> YES <input type="checkbox"/> NO
Date/Time:	
Level of urgency:	<input type="checkbox"/> Urgent <input type="checkbox"/> High <input type="checkbox"/> Moderate <input type="checkbox"/> Low

Appointment 3 Details (if applicable)

Discipline (either medical specialist or allied health):	
Organisation Name:	
Phone number:	
Is the appointment booked?:	<input type="checkbox"/> YES <input type="checkbox"/> NO
Date/Time:	
Level of urgency:	<input type="checkbox"/> Urgent <input type="checkbox"/> High <input type="checkbox"/> Moderate <input type="checkbox"/> Low



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

Reasons these Support Services are required	
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 services/equipment is 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"/>

PATIENT CONSENT

My GP/Nurse/Health Worker has told me about Nhulundu Health Service ITC program and I want to participate. I understand what I have been told and any questions I had have been answered. I understand that services (Service providers including my GP 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 Coordinator. 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 ITC Program 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, staff capacity and available funding.

Please send the signed Referral to:

itc@nhulundu.com.au



INTENTIONALLY LEFT BLANK

Patient Copy – Please give to patient once Consent is signed

PATIENT CHARTER - Nhulundu Health Service

As a patient accessing Nhulundu Health Service ITC program 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 people, 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.

If you have any questions, issues, or concerns, please contact Nhulundu Health Service ITC Program on:

(07) 4979 0992

or

itc@nhulundu.com.au