Bidgerdii Community Health Service

ITC/Allied Health Support Services GP Referral Form

The ITC (Integrated Team Care) program aims to contribute to improving health outcomes for Aboriginal and Torres Strait Island people with chronic health conditions through better access to coordinated and multidisciplinary care by achieving better treatment and management of their chronic conditions.

Please FAX completed and signed Referral to : GO Fax - 35325150

PRACTICE DETAILS					
Name					
Address					
Phone Number					
Fax Number					
REFERRING GP					
Name					
Provider Number					
Email Address					
PATIENT DETAILS					
Name					
Address					
Gender	☐ Male ☐ Female ☐ Intersex/Other ☐ Not Stated				
DOB		**Medicare Number**			
Phone Number					
Mobile Number					
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		
Next of Kin or Support Person					
Name		**Phone Number**			
PATIENT ELIGBILITY					
Patient identifies as?	☐ Aboriginal ☐ Torres Strait Islander ☐ Aboriginal and Torres Strait Islander				
Patient is Register in the PIP-IHI?	☐ YES ☐ NO				
Patient has completed a 715 Health Check	☐ YES ☐ NO				
Patient has a current GPMP and/or TCA (<12 months old)	☐ YES ☐ NO				
Patient has a diagnosed Chronic Disease	☐ Cancer ☐ Cardiovascular Disease ☐ Diabetes ☐ Chronic Kidney (Renal) Disease ☐ Chronic Respiratory Disease ☐ Chronic Mental Health ☐ Other Chronic Disease *(Please List)* _____				

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CARE CO ORDINATION CRITERIA	
Reason Co Ordination is required	
Patient is at significant risk of experiencing otherwise avoidable (Lengthy and/or frequent) hospital admissions	☐
Patient is at risk of inappropriate use of services such as hospital emergency presentations	☐
Patient is not using community based services appropriately or at all	☐
Patient needs help to overcome barriers to access services	☐
Patient is unable to manage a mix of multiple community-based services	☐
Patient Requires Care Co ordination	☐ YES ☐ NO
Level of Assistance	☐ Low ☐ Medium ☐ High
Duration of Assistance	☐ Short Term (Less than 6 months) ☐ Mid Term (6-12 months) ☐ Long Term (12 months or More)

SUPPORT SERVICES CRITERIA		
Reasons these Support Services are Required		
To address risk factors, such as waiting period for a service longer than is clinically appropriate	☐	
To reduce the likelihood of an hospital admission	☐	
To reduce the patient's length of stay in hospital	☐	
As services/equipment are 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	☐	
Support Services required as per Care Plan		
	Select	Comments
Allied Health Services *(please specify)*	☐	
Specialist Services *(please specify)*	☐	
Transport	☐	
Accommodation Gap Fee Assistance	☐	
Diagnostic testing (MRI, Blood Test, X-Ray)	☐	
Nebuliser & other asthma (assistive breathing) related equipment	☐	
CPAP equipment (Machine and or mask)	☐	
Glucometer & diabetes related equipment	☐	
DAA (Dose Administration Aids) (dietary supplements , Webster Pack Fee) Note: Medication is not covered	☐	
Orthotics and Footwear (Prescribed and fitted by Podiatrist)	☐	
Spectacles (If not eligible for MASS-SSS)	☐	
Mobility Aids or Shower Chairs (Prescribed by an Occupational Therapist or Physiotherapist)	☐	
Other *(Please specify)*	☐	

Other Funding Sources to be considered before referring to the ITC/Allied Health Support Services:

- ☐ MASS (Medical Aids Subsidy Scheme)
- ☐ NDSS (National Diabetes Subsidy Scheme)
- ☐ HACC (Home and Community Care)
- ☐ QUMAX (Quality Use of Medicines for Aboriginal and Torres Strait Islander people)
- ☐ PTSS (Patient Travel Subsidy Scheme)
- ☐ Centrelink Essential Medical Equipment Payment – electricity subsidy for running medical equipment such as CPAP, home dialysis, nebuliser etc

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APPOINTMENT 1 DETAILS *(If applicable)*	
Discipline *(either medical specialist or allied heath)*	
Organisation Name	
Phone Number	
Is the appointment Booked	☐ YES ☐ NO
Date /Time	
Level of Urgency	☐ Urgent ☐ High ☐ Medium ☐ Low

APPOINTMENT 2 DETAILS *(If applicable)*	
Discipline *(either medical specialist or allied heath)*	
Organisation Name	
Phone Number	
Is the appointment Booked	☐ YES ☐ NO
Date /Time	
Level of Urgency	☐ Urgent ☐ High ☐ Medium ☐ Low

PAITENT CONSENT
(Tick box if consent is given)

☐ ITC/ALLIED HEALTH PROGRAM CONSENT

My GP or Care Coordinator has discussed the ITC/Allied Health 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 participate.

- I understand that my participation is voluntary and that I have the right to withdraw from the Program at any time.
- I understand and know that I can withdraw this consent at any time. To withdraw my consent, I must send a written and signed note to my Care Coordinator. The withdrawal will be valid as soon as the Care Coordinator receives my note, but will not apply to information that has been shared since my initial consent.
- I understand that range of health and community service providers may collect, use and disclose my relevant personal information as party 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 the ITC/Allied Health Program to discuss required services and care coordinator.

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

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

☐ **HOME MEDICATION REVIEW (HMR) CONSENT**

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

Patient Name	
Patient Signature	
Date	

AUTHORISATION
(Consent explained and referral authorised By)

I have discussed the proposed referral to Bidgerdii Community Health Service ITC/Allied Health Program with the patient and am satisfied that the patient understands and is able to provide informed consent to this.

Referring GP's Name	
Signature	
Provider Number	
Date of Referral	

CONFIRMATION OF REFERRAL

As a Care Coordinator, I can confirm I have received the above referral to the ITC / Allied Health Support Services Program offered by Bidgerdii Community Health Service.

Name	
Signature	
Date Referral Received	

DISCLAIMER

Approval of the ITC/Allied Health Support Services requested will be on a priority basis and contingent on staff capacity and available funding.
Bidgerdii Community Health Service promotes the ***Self-Management*** of Patients Health and encourages patient to be more active in the management of their health.