Care Coordination

& Supplementary Services

**Integrated Team Care Program (ITC)**

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.

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| **Practice Details** |  |
| Practice/ACCHO Name: |       |
| Practice/ACCHO Address: |       |
| Phone Number: |       |
| Fax Number: |       |
| Referring GP Name: |       |
| GP Email: |       |

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| **Patient Details** |  |
| Name: |       |
| Gender: | [ ]  Male. [ ]  Female. [ ]  Other *(please indicate).*       |
| Date of Birth: |   |
| Residential Address: |       |
| Postal Address:  |       |
| Contact Phone No: |        |
| Next of Kin - Name |        |
| Next of Kin - Phone |        |
| Medicare Number |       | Expiry Date |   |
| Health Care Card | [ ]  Yes. [ ]  No.  | Pension Card | [ ]  Yes. [ ]  No.  |
| DVA | [ ]  Yes. [ ]  No.  | Private Insurance | [ ]  Yes. [ ]  No.  |
| Smoking Status | [ ]  Yes. [ ]  No.  |  |  |
| Willingness to use Telehealth | [ ]  Yes. [ ]  No.  |  |  |

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| **Program Eligibility** |  |
| Does the patient identify as Aboriginal and/or Torres Strait Islander? ***Patient must be Aboriginal and/or Torres Strait Islander to be eligible*** | [ ]  Aboriginal [ ]  Torres Strait Islander [ ]  Aboriginal and Torres Strait Islander |
| Does the patient have a current GPMP and/or TCA (<12months old) ***Patient must have a GPMP and/or TCA in place to be eligible*** | [ ]  Yes. [ ]  No.  |
| Please list the patient's Chronic Condition/s (NB: Private dental services are not covered)***Patient must have a chronic condition to be eligible*** | [ ]  Cancer [ ]  Chronic Mental Health[ ]  Diabetes [ ]  Chronic Respiratory Disease[ ]  Cardiovascular Disease [ ]  Chronic Kidney Disease[ ]  Chronic Respiratory Disease [ ]  Other Chronic Disease *(please specify below)*                |

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).

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

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| Billing Date |   |
| GP Signature |  |

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| **Support Services Required as per Care Plan** |
| **Equipment** | **Select** | **Comment** |
| Assisted breathing equipment | [ ]  Yes. [ ]  No.  |        |
| Blood sugar/monitoring equipment | [ ]  Yes. [ ]  No.  |        |
| Dose administration aids | [ ]  Yes. [ ]  No.  |        |
| Medical footwear *(prescribed and fitted by a podiatrist)* | [ ]  Yes. [ ]  No.  |        |
| Mobility aids or shower chairs | [ ]  Yes. [ ]  No.  |        |
| Spectacles *(if not eligible for MASS - SSS)* | [ ]  Yes. [ ]  No.  |        |
| [ ]  Other (*please specify*) |        |

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| **Other Details** |
| **If travel is required, has PTSS been organised?** *If so, please attach details to this referral****.***  | [ ]  Yes. [ ]  No.  |
| **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.  |

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| **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 thse cost of a local transport service | [ ]  |

*Please see next page for Appointment details (if applicable)…*

Appointments

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| **Appointment 1 Details** (if applicable) |
| Discipline - medical specialist / allied health:  |       |
| Organisation Name:  |       |
| Phone number: |       |
| Is the appointment booked? | [ ]  Yes. [ ]  No.  |
| Date |   | Time |       :       [ ]  am. [ ]  pm.  |
| Level of urgency: | [ ]  Urgent [ ]  High [ ]  Moderate [ ]  Low  |

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| **Appointment 2 Details** (if applicable) |
| Discipline - medical specialist / allied health:  |       |
| Organisation Name:  |       |
| Phone number: |       |
| Is the appointment booked? | [ ]  Yes. [ ]  No.  |
| Date |   | Time |       :       [ ]  am. [ ]  pm.  |
| Level of urgency: | [ ]  Urgent [ ]  High [ ]  Moderate [ ]  Low  |

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| **Appointment 3 Details** (if applicable) |
| Discipline - medical specialist / allied health:  |       |
| Organisation Name:  |       |
| Phone number: |       |
| Is the appointment booked? | [ ]  Yes. [ ]  No.  |
| Date |   | Time |       :       [ ]  am. [ ]  pm.  |
| Level of urgency: | [ ]  Urgent [ ]  High [ ]  Moderate [ ]  Low  |

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| **Appointment 4 Details** (if applicable) |
| Discipline - medical specialist / allied health:  |       |
| Organisation Name:  |       |
| Phone number: |       |
| Is the appointment booked? | [ ]  Yes. [ ]  No.  |
| Date |   | Time |       :       [ ]  am. [ ]  pm.  |
| Level of urgency: | [ ]  Urgent [ ]  High [ ]  Moderate [ ]  Low  |

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| **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 |       |
| Signature |  |
| Date |   |

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| **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 GRAICCHS t/a Nhulundu Health Service: (07) 4979 0992*



*Patient Copy – Please give to patient once Consent is signed*

Patient Charter

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| **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***