GP REFERRAL FORM

Fax to 02 4702 6139

Email to ctg@nepeancommunity.org.au

Closing the Gap Program – Care Coordination and Supplementary Services Program

To be eligible for the CTG Program, a person must:

- ☐ Be an Aboriginal and/or Torres Strait Islander Person
- ☐ Have complex care needs, requiring multidisciplinary coordinated care
- ☐ Have one or more of the following chronic conditions

Tick the box (s):

- ☐ Diabetes
- ☐ Cancer
- ☐ Chronic Renal Disease
- ☐ Cardiovascular Disease
- ☐ Chronic Respiratory Disease

Chronic and complex condition requiring more intensive care coordination

*(**Please complete details which will be assessed as to whether the program has the capacity to support the care coordination required)* _____

_____

- ☐ Have, or be willing to get, a chronic disease GP management Care Plan

This referral is for:
(Referrer to complete)

- ☐ Care Coordination
- ☐ Outreach Workers
- ☐ Both

Referral Date:____/____/_____

Patient Details

First Name: _____ **Surname:** _____

Date of Birth: _____ **Gender (please circle): Male / Female / Other:**

Address: _____

Preferred Contact Number: _____ **Email:** _____

Medicare Number: _____( ) **Expiry:** _____

Pension Card: Y / N **Type:**_____ **Number:** _____

Carer's Name (if patient 15 years and under) _____

Carer's Contact Number: _____

Carer's Address: _____

GP or other service Referrer:

Name and Address (Practice / Other referrer): _____

Name (individual GP referring / Other service referrer) : _____

Contact No:_____Fax No: _____ Email: _____

Reason for Referral (tick all that apply).

Note: Priority will be given to patients who have complex needs and require multidisciplinary coordinated care for their chronic disease i.e. patients who are at greatest risk of avoidable hospital admissions

Complex Chronic Disease Care Coordination required:

- ☐ Coordination of Specialist Appointments - as per GP care plan
- ☐ Attendance at Specialist Appointments
- ☐ Self-Management Skills
- ☐ Other: Specify _____

Supplementary Services Program - Assistance with payment for one of more of the following services:

Note: Supplementary services is not intended to follow up all care. Priority will be given to patients who are not able to access services through the public health system in a clinically acceptable timeframe or where transport is inaccessible or unaffordable

- ☐ Transport
- ☐ Specialist Services/gap payment
- ☐ Dose Administration Aids (DAAs)
- ☐ MRI, Radiology and Pathology
- ☐ Allied Health Services
- ☐ Medical footwear (prescribed by and fitted by a podiatrist)
- ☐ Medical Equipment (including: asthma masks, spacers and nebulisers, Continuous Positive Airways Pressure (CPAP) machines and accessories, blood sugar/glucose monitoring equipment)

Any other assistance requested/further information (e.g. other specialists/Allied Health Providers involved in patient's care? _____

_____

Consent

My GP and Care Coordinator have 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 participations 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.
- This information will be held securely on paper and on computer in accordance with relevant privacy legislation.

Patient name and signature:

_____ **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 referral.

GP name and signature:

_____ **Date:**_____/_____/_____