



GP REFERRAL FORM

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Closing the Gap Program – Care Coordination and Supplementary Services Program

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

Referral Date: ____/____/____

- ☐ 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

- ☐ Have, or be willing to get, a chronic disease GP Management Plan (721)
- ☐ And GP to provide a Copy of Client's Care Plan (721)

Patient Details

First Name: _____ Surname: _____

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

Address: _____

Preferred Contact Number: _____ Email: _____

Medicare Number: _____ () Index no_ Expiry: _____

Pension/Health Care Card: Y / N Type: _____ Number: _____

Start: _____ Expiry: _____

Are you registered with the **Healthy for Life Program**? Yes ☐ No ☐

Are you registered with **NDIS**? Yes ☐ No ☐

NDIS Number: _____ **Provider:** _____

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

Carer's Contact Number: _____

Carer's Address: _____

GP:

Name and Address (Practice): _____

Name (individual GP referring): _____

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)
- ☐ Medical Equipment (including: - Asthma masks, Spacers and nebulisers, Continuous Positive Airways Pressure (CPAP) machines and accessories, Blood sugar/glucose monitoring equipment)
- ☐ MRI, Radiology and Pathology
- ☐ Allied Health Services
- ☐ Medical footwear (prescribed by and fitted by a podiatrist)

Other assistance requested/further information

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 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.
- 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: ____/____/____

GP CTG Referral Checklist

We will need:

- A completed and signed GP CTG CCSS referral
- A signed Patient Consent (on pg2 of the GP referral)
- A signed copy of patient's GPMP (721)
- A signed copy of patient's TCA (723) (where applicable)
- A completed and signed copy of each completed EPC (where applicable)
- A copy of the referral to the relevant Specialist
- A copy of the referral to Outpatients Clinic

 The Closing the Gap Program guidelines provides for registered patients to access medical specialist health services that are not accessible through the public health system in a clinically acceptable timeframe.

As such, we request that patients be referred to the appropriate out-patients services, for ongoing support, to ensure sustainability for both patient and program.