Referral Form - Integrated Team Care

For Aboriginal and Torres Strait Islander patients needing assistance managing their chronic disease

Eligibility

Aboriginal and/or Torres Strait Islander	□ Yes	□ No
Consumer consents to referral	□ Yes	□ No

Supporting documents (these documents are essential in registering a client with the GPH ITC program)

☐ Aboriginal and Torres Strait Islander (MBS Item 715) Health Assessment
☐ GP Management Plan
☐ Team Care Arrangement

1. Patient Details:

Name:	Date of Birth:
Gender:	Medicare Number:
Contact Number:	Medicare Expiry:
Allergies:	Address:

2. Emergency Contact

Name:
Emergency Contact number:
Relationship to Consumer:

3. Chronic Disease Details:

Client must have a chronic medical condition which has been, or is likely to be present for at least six months

☐ Diabetes	☐ Eye Conditions (assoc.with diabetes)	☐ Chronic Kidney Disease
☐ Cancer	☐ Cardiovascular Disease	☐ Chronic Respiratory Disease
☐ Mental Health	☐ Other *(please provide details below):*	

Other relevant information:

4. The reason my patient requires Care Coordination / Supplementary Services is:

(e.g. Inability to self-manage, functional disability etc)

Reviewed 31/1/2022

5. Referrer Details

GP Name	
GP Signature	
GP Practice	
GP Secure Email	
Date of Referral	

Referral Instructions:

1. Send this referral form with completed MBS 715 Aboriginal and Torres Strait Islander (MBS Item 715) Health Assessment and GPMP / TCA to ITC Intake Coordinator
2. Please also include Care Coordinator as part of the GPMP / TCA team

ITC Intake Coordinator

Phone 1800 879 096 or 02 4448 2200
Fax 02 4448 2289
Argus Argus.gphsouthern@gph.org.au
Healthlink gphs8uth