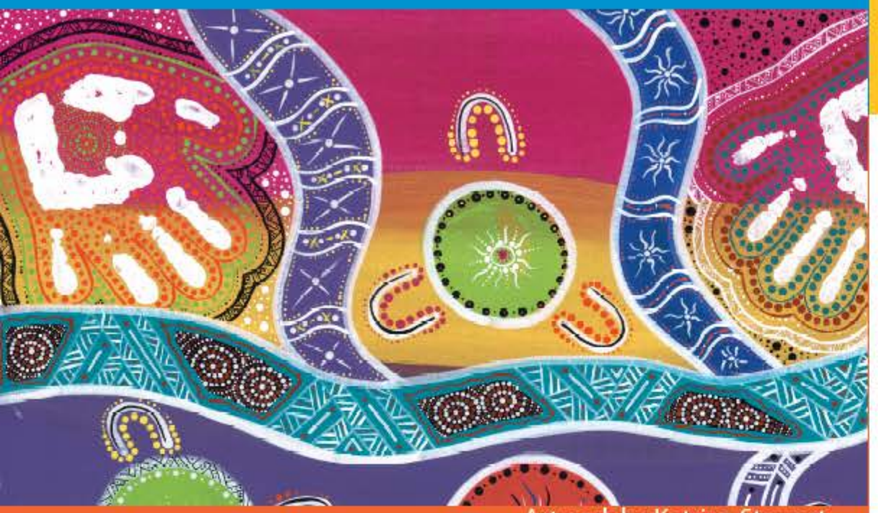

Artwork by Katrina Stewart

Eligibility

- Aboriginal or Torres Strait Islander
- Available to all ages
- Diagnosed with a chronic illness
- Registered with Medicare
- Have a current GP Management Plan and/or Team Care Arrangement

How to Access the Integrated Team Care Program:

1. GP obtains client consent
2. GP submits client consent and copy of CARE PLAN using contact details on the back of this brochure
3. A Care Coordinator will then contact the client and discuss/arrange appointment
4. Care Coordinator liaises with GP regarding clients care plan

For GP referral and client consent forms, please visit:
www.gph.org.au/our-health-services/chronic-disease-management/

THERE IS NO COST TO ACCESS THE PROGRAM

We acknowledge the traditional land owners past and present on whose land we work and live.

For more information about the Integrated Team Care Program in the Illawarra, Shoalhaven, Bega Valley, Cooma-Monaro, Goulburn, Queanbeyan, Yass or A.C.T regions, please contact:

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

Or access the referral form by scanning the QR code below:

www.gph.org.au/our-health-services/chronic-disease-management/
For referral forms and location details

Grand Pacific Health Ltd. ABN 49 062 587 071

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Integrated Team Care

Artwork by Rod Seymour

Information for clients and health professionals

Grand Pacific Health

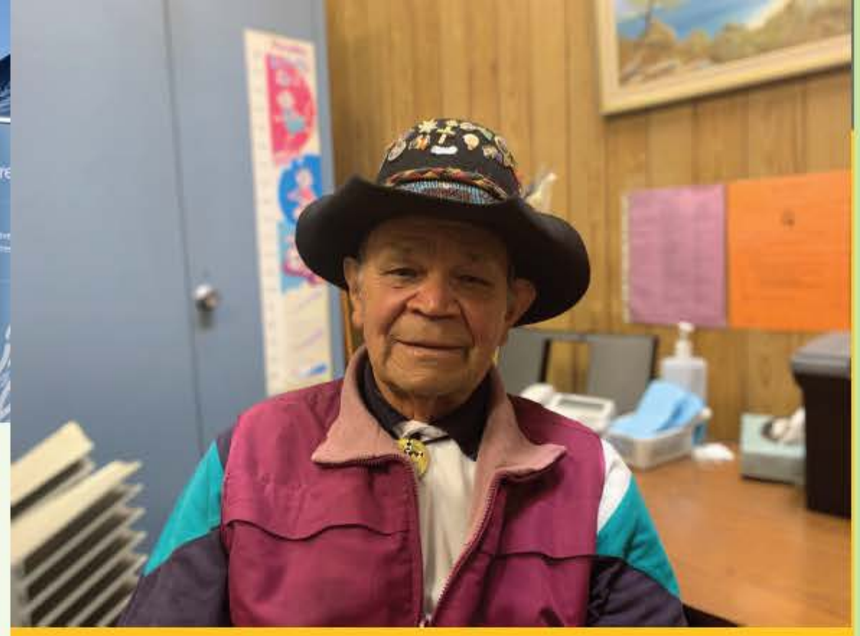
THE INTEGRATED TEAM CARE PROGRAM

What is a Care Coordinator?

- A Care Coordinator is a nurse or other health worker who is a key contact person for you and is also able to discuss/arrange your specialist appointments.
- The Care Coordinator can help link you with medical services to improve your health and help you better understand your chronic disease.
- The Care Coordinator only discusses your information with your doctor and/or other health professionals with your permission.

The Care Coordinator will:

- Listen to you, and give you any information you need about your illness to help you improve your health.
- Work with you and your doctor (GP) to arrange the best treatment plan for you.
- Assist you in arranging appointments with medical specialists and allied health providers such as physiotherapists, podiatrists, diabetic educators etc.



What is a chronic disease?

A chronic disease is an illness that can last six months or more and has an impact on your everyday life.

Example of chronic diseases include:

- diabetes (sugar levels in the blood)
- heart disease (for example high blood pressure)
- lung disease (for example asthma)
- kidney disease
- cancer

Would you like...

- information to help you better understand your chronic disease?
- information or help to find services to support you?

What do I need to do to access this service?

- Please give your consent to your doctor and they will provide your contact details to the Care Coordinator.

What will happen then?

- The Care Coordinator will contact you to discuss and arrange your specialist appointment.
- The Care Coordinator will discuss with you and your doctor your chronic disease treatment plan.
- The Care Coordinator will link you to appropriate services to help you better manage your chronic disease.
- Your Care Coordinator will help you access services by organising transport if necessary.
- Together with your doctor the Care Coordinator will support you and help you improve your health and wellbeing.

THIS SERVICE IS ABOUT YOUR HEALTH!