

For your **Aboriginal and Torres Strait Islander clients** needing assistance managing their chronic disease

Aboriginal and/or Torres Strait Islander Yes

No (Not eligible to participate)

1. Patient Details:

Name	Date of Birth
Contact Number	Medicare Number
Address	

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

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

3. Service Required:

<input type="checkbox"/> Care Coordination	<input type="checkbox"/> Supplementary Services:	<input type="checkbox"/> Specialist Care	<input type="checkbox"/> Allied Health
		<input type="checkbox"/> Transport	<input type="checkbox"/> Medical Aids

4. Supporting Documents:

<input type="checkbox"/> GPMP (<i>essential</i>)	<input type="checkbox"/> TCA (<i>useful</i>)	<input type="checkbox"/> 715 (<i>optional but useful</i>)
<input type="checkbox"/> Other:		

5. Chronic Disease Details:

Patient must have a chronic or terminal medical condition which has been or is likely to be present for six months or longer

<input type="checkbox"/> Diabetes	<input type="checkbox"/> Eye Conditions (assoc.with diabetes)	<input type="checkbox"/> Chronic Kidney Disease
<input type="checkbox"/> Cancer	<input type="checkbox"/> Cardiovascular Disease	<input type="checkbox"/> Chronic Respiratory Disease
<input type="checkbox"/> Mental Health	<input type="checkbox"/> Other (<i>details</i>):	

6. Priority Allocation of Supplementary Services Funding:

- Likely to prevent hospital admission
- Likely to reduce hospital admission length of stay
- Risk of inappropriate use of services, such as hospital emergency presentations
- Service requested is unavailable through other funding sources
- Waiting period for the service is longer than clinically appropriate
- No availability of local transport for patient to attend specialist or allied health appointment
- Prohibitive transport cost for the patient to attend specialist or allied health appointment

GP Name	
GP Signature	
GP Practice	
Date of Referral	

Referral Instructions

1. Send this referral form with GPMP / TCA to relevant Care Coordinator in your region
2. Please also include Care Coordinator as part of the GPMP / TCA team

Illawarra

Phone 02 4220 7645
 Fax 02 4226 6489

Shoalhaven

Phone 02 4448 2203
 Fax 02 4448 2289

Eurobodalla

Phone 02 4474 2783
 Fax 02 4474 0418
 Argus Argus.gphsouthern@gph.org.au

Bega Valley & Cooma-Monaro

Phone 02 6494 8860
 Fax 02 6494 8855
 Argus Argus.gphsouthern@gph.org.au

Goulburn, Yass & Queanbeyan

Phone 02 4824 4905
 Fax 02 4824 4990
 Argus Argus.gphsouthern@gph.org.au

Canberra

Phone 0436 189 481
 Fax 02 4474 8587

For internal use:

Referral Accepted Referral Declined Referral on Waiting List

Date of referral receipt: _____ Date of referring GP contact: _____

Date of client first contact: _____ Date for referral review: _____