General Practitioner Referral Form

IWC - ITC (Integrated Team Care) Program

Please fax completed form to (07) 3811 6467

OR

send via Medical Objects to - ITC IWC - BUNDABERG (II467000070)

Program Eligibility			
Is this patient currently registered in the Indigenous Health Incentive?	☐ Yes ☐ No		
Has this patient had a health assessment (MBS 715) in the last 9-12 mths?	☐ Yes ☐ No	Date of 715 Assessment:	_____/_____/20_____
This patient has a current GP Management Plan and/or Team Care Arrangement? (must be completed to be eligible)	☐ Yes ☐ No	Is a copy of the patient's GP Management Plan and/or Team Care Arrangement Attached?	☐ Yes ☐ No
The patient's chronic disease type/s Please write			
Reason for Referral (tick one or more as appropriate) Please attach copies of Referrals to Specialist if required	☐ Specialist - Name of specialist:	☐ Identify Discipline	
	☐ Care Coordination		
	☐ Medical Aids ☐ Dose Administration Aids (DAAs) ☐ Assistive Breathing Equipment (Asthma Spacers; Nebulisers; Masks for Spacers and Nebulisers) ☐ Continuous Positive Airways Pressure (CPAP) Machines ☐ Accessories for CPAP Machines ☐ Blood Sugar/Glucose Monitoring Equipment ☐ Medical Footwear that is prescribed and fitted by a Podiatrist. ☐ Other_____		
Source of referral	☐ **General practice**		
Referring GP details			
Referring GP Name		Provider Number:	
Practice name			
Patient details			
Surname:	**First Name:**	**Date of Birth:**	**Gender: ☐ Male ☐ Female**
Does this patient Identify as:	☐ Aboriginal ☐ Torres Strait Islander ☐ Both **Medicare Number:** _____ Patient ID on card _____ Expiry Date ____ /_____		**DVA Card type & No:** _____ **Health Care Card:** _____ Expiry Date____ **/** _____
Address:	Post Code:		

Phone number	Home:	Work:	Mobile:
The reason my patient requires Care Coordination services (tick 1 or more as appropriate)	☐ is at significant risk of experiencing otherwise avoidable (lengthy and/or frequent) hospital admissions ☐ is at risk of inappropriate use of services, such as hospital emergency presentations ☐ may not be using community based services appropriately ☐ needs help to overcome barriers to access services ☐ requires more intensive care coordination than is currently able to be provided by general practice/Indigenous Health Service staff		
Reason patient requires Supplementary Services (i.e. medical specialist/allied health/local transport services in accordance with the care plan (tick 1 or more as appropriate)	☐ to address risk factors, such as a waiting period for a service longer than is clinically appropriate ☐ to reduce the likelihood of a hospital admission ☐ to reduce the patient's length of stay in hospital ☐ as not available through other funding sources ☐ to ensure access to a clinical service that would not be accessible because of the cost of a local transport service ☐ Medical Item		☐ None required at present
Referral authorised by: GP name, signature and stamp			
Date	___/___/___		

Patient information and consent

My GP or Care Coordinator has discussed the ITC 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.
- I understand that I am obliged to attend all scheduled appointments and that non-attendance will result in me being responsible for any associated fees and withdrawal of ITC and Specialist services.
- I understand that it is my responsibility to ensure that any medical aids supplied to me, are kept clean and maintained according to manufacturer's recommendations to ensure efficient operation.
- I will attend any follow up appointments as part of the monitoring and treatment plan regarding the use and effectiveness of the medical aide as requested by the Care Coordinator or provider.
- I understand that the IWC may process a Medicare claim for any Specialist service I may receive.
- **I understand that I am obliged to attend all scheduled appointments and that non-attendance will result in being responsible for any associated fees and will result in withdrawal of ITC support.**

Patient Name and Signature	
Print Name	
Signature	
Date	___/___/___

If you require further information regarding the ITC program please contact:

Care Coordinator
Bundaberg
Ph: 1300 492 492

Can we provide your patient with a copy of the GPMP?

Yes ____

No _____