Closing The Gap: Integrated Team Care (ITC) Referral Form

Please fax to **9192 7999** or send to "**Boab Health Allied**" via MMEx

This service is available to Aboriginal and/or Torres Strait Islander patients ONLY

Priority:	☐ Urgent ☐ Routine	Date of Referral _ _/ _ _/ _ _ _ _
Patient identifies as:	☐ Aboriginal ☐ Torres Strait Islander	☐ Aboriginal and TSI
GP Management Plan attached with Referral ☐ Yes ☐ No Allied Health Referral attached (if required): ☐ Yes ☐ No		
The patient's chronic condition type/s :	☐ Diabetes ☐ Cancer ☐ Cardiovascular disease ☐ Chronic Kidney disease ☐ Chronic respiratory disease ☐ Mental Health condition ☐ Other (please specify) _____	

GP Details :			
Name:		Practice :	
Phone :			
Patient Details :			
Surname:		First Name:	
Date of Birth:	_ _/ _ _/ _ _ _ _	Gender	☐ Male ☐ Female
Address:		Phone	
Medicare N°	☐☐☐☐☐☐☐☐☐☐-☐ **Exp. Date:** ☐☐ /☐☐		

Care Coordinator- Please indicate assistance required**:**

- ☐ Assist client with care plan compliance and adhering to medication and treatment regimes
- ☐ Arrange appointments for diagnostic tests, allied health professionals or specialists
- ☐ Provide education on the client's chronic condition and promote self-management
- ☐ Connect with other community based services

Supplementary Services - Please indicate financial support required:

- ☐ Transport support to attend appointments
- ☐ Access to private specialist/health professional if public is not available, or waiting list is inappropriate for patient's condition
- ☐ Financial assistance with **approved** medical aids. *(Glasses, assisted breathing equipment, podiatry approved shoes, dose administration aids, blood sugar monitoring equipment, mobility aids, shower chairs)*

Please specify what aid is required: _____

- ➢ My GP and I have discussed the ITC Program. I understand and want to participate.
- ➢ I understand that my participation is voluntary and I can 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 information, including my GP Management Plan as part of my care.

Patients Signature: _____ *Date:* _ _/ _ _/ _ _ _ _

GP Signature: _____ *Date:* _ _/ _ _/ _ _ _ _

Boab Health Services Pty Ltd

Broome Office
Unit 5, 20 Hamersley Street | PO Box 1548 Broome, WA 6725
T 08 9192 7888 | F 08 9192 7999 |

Kununurra Office
Coolibah Centre, 96 Coolibah Drive | PO Box 1866 Kununurra, WA 6743
T 08 9168 2560 | F 08 9168 3305 |

reception@boabhealth.com.au | www.boabhealth.com.au | ABN: 86 105 341 866

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