

GP Referral Form



Aboriginal Health

WA Integrated Team Care Program

This program supports Aboriginal and Torres Strait Islander people with complex chronic care needs to improve self-management of their condition in partnership with their GP.

Referring GP Details: (stamp accepted)

Name:

Practice:

Practice Address:

Phone:

Fax:

Patient Details:

First Name:

Date of Birth:

Surname:

Phone:

Residential Address:

Postcode:

Next of Kin/Alternate Contact:

Alternate Contact Phone:

My patient meets ALL the criteria below (tick applicable):

- ☐ Is Aboriginal and/or Torres Strait Islander
- ☐ Has chronic health needs requiring complex and/or multidisciplinary care
- ☐ Has a chronic condition management plan

Type of Chronic Disease Management Plan (attached)

- ☐ Current GP Management Plan MBS721

Interim referral options are accepted but a GPMP must be provided *within three months*

- ☐ Referral by non-usual GP or Remote Area Nurse (RAN) with an interim CDM care planⁱ, or
- ☐ Team Care Arrangements MBS723; or
- ☐ Current Aboriginal Health Check MBS715 and is registered for PIP IHI for CDM with referring practiceⁱⁱ

Chronic Condition Details (tick applicable)

- ☐ Diabetes
- ☐ Chronic renal disease
- ☐ Co-occurring mental health condition
- ☐ Cardiovascular disease
- ☐ Chronic respiratory disease
- ☐ Cancer
- ☐ Otherⁱⁱⁱ

Is another organisation already currently providing Care Coordination? If yes, specify:

Eg. Aboriginal Community Controlled Health Service; ICDC Program; Aged Care Provider. Provide Client ID Number if available

NDIS and Aged Care:

Is the client registered for NDIS: ☐ Yes ☐ No ☐ In progress

Is the client registered for Aged Care support: ☐ Yes, Level (circle): 1 2 3 4 ☐ No ☐ In progress

The ITC Program must not duplicate services for people eligible for a funded package.

Reason/s for ITC Referral:^{iv}

- ☐ Requires Supplementary Services support
- ☐ Requires Care Coordination support

THE ITC PROGRAM IS ONLY ABLE TO PROVIDE SUPPORT RECOMMENDED IN THE GP CARE PLAN
AND NOT AVAILABLE THROUGH OTHER MEANS.

Comments:

Patient Information and Consent

My GP has explained the purpose of this referral for the ITC Program; I give permission for my care plan to be shared with the ITC Provider; and for the ITC Provider to contact me to discuss how the ITC Program can support me in my care plan needs.

Patient signature:

GP signature:

Verbal consent (where signature not practicable^v) ☐

Date:



Client Registration and Consent Form



WA Integrated Team Care Program

The Integrated Team Care (ITC) Program supports Aboriginal and Torres Strait Islander people with complex chronic care needs to improve self-management of their condition in partnership with their GP. It is the responsibility of the ITC Provider to support clients to understand and complete the form to ensure informed consent.

Patient Details:

First Name:	Date of Birth:
Surname:	Phone:
Residential Address:	Postcode:
Medicare Number:	Ref No:
Health Care / DVA Card Number:	Expiry:
Primary Language Spoken:	Interpreter Required: ☐ Yes ☐ No
Gender: ☐ Male ☐ Female ☐ Indeterminate / Intersex / Unspecified	
Ethnicity: ☐ Aboriginal ☐ Torres Strait Islander ☐ Aboriginal & Torres Strait Islander	

Next of Kin Details:

First Name:	Relationship:
Surname:	Phone:
Residential Address:	Postcode:

Emergency Contact Details:

First Name:	Relationship:
Surname:	Phone:
Residential Address:	Postcode:

Additional Details:

Do you have dependent children living at home:	☐ Yes ☐ No	If yes, number of children:
Are you the primary carer for another person:	☐ Yes ☐ No	
Do you have mobility issues:	☐ Yes ☐ No	
Do you have access to transport:	☐ Yes ☐ No	

Client Consent

To register for the ITC Program please read the information below and tick to confirm that each point has been explained by an ITC staff member, and that you understand/consent as applicable. Text in **blue** indicates where you may select either Yes or No and still be registered for the ITC Program.

Protecting Your Privacy	The ITC Program is committed to providing you with the highest level of service and confidentiality. The ITC Program is bound by the Commonwealth Privacy Act 1988 and the Privacy Amendment (Private Sector) Act 2000.	☐ Yes
Information Management	All information collected about you is confidential and will be stored securely. You may request to see information held about you, or withdraw from the ITC Program, at any time. The documents released to the ITC Provider from your GP (or hospital, or other relevant health provider) may contain information including, but not limited to, history, diagnoses, and/or treatment of mental illness or communicable disease. The provided information is stored securely, and will remain confidential between you, your GP (or other relevant health provider) and the ITC Provider. Information retained by the ITC Provider cannot be disclosed to a third party without your written authorisation, except where otherwise permitted by law.	☐ Yes



Collection, Exchange and Disclosure of Information	Communication between your GP and ITC Provider: The ITC Provider will support your GP to help you to manage your chronic condition. Your GP must provide a copy of your GP Care Plan to the ITC Provider including recommendations for ITC support. Depending on the recommendations the ITC Provider may require additional information/documents (such as copies of: GP Management Plan; Team Care Arrangements; or allied health and specialist referral forms). The ITC Provider will provide your GP with updates on your progress toward completion of the GP Care Plan, and recommendations for ongoing management of your health condition. Your ITC Provider will require copies of 3-6 monthly reviews of your GP Management Plan.	☐ Yes
	Communication with Allied Health and Specialist Services: Information needed to coordinate appointments with referred Allied Health and Specialists will only be disclosed with verbal consent from yourself. Sharing of clinical information will require your written consent.	☐ Yes
	Communication with Hospitals: If you are admitted to hospital while registered for the ITC Program your ITC Provider and hospital staff involved in your care may liaise to confirm that you are registered for the ITC Program and to discuss your health needs once you are discharged. The hospital may provide your ITC Provider with a copy of your discharge summary.	☒ Yes ☒ No
	Communication with other ITC Providers: if you are outside your current ITC region, but still within WA, another ITC Provider may be able to assist you. To do this your current ITC Provider will need to share information about your care needs to the other ITC Provider. An ITC Provider will discuss this with you and request additional consent for the inter-region support/transfer process as needed.	☐ Yes
Cancellations	You must provide the ITC Provider and health services 24 hours' notice to cancel an appointment. Failure to do so may result in the appointment being considered a 'Did Not Attend' (DNA) by the health service. A DNA may result in you being re-assigned to the waitlist. Continuous DNA may result in review of your registration with the ITC Program.	☐ Yes
Transport Support	The ITC Program supports clients without access to transport to attend essential health care appointments. This may include coordination with other services who provide transport; assistance to access public transport; or provision of transport by an ITC staff member when available. Where no other transport option is available, a voucher may be provided. Vouchers must only be used for direct travel to and from appointments; and the receipt must be returned to the ITC Provider. You are financially responsible for any misuse of the voucher. Any misuse may result in suspension from future transport support.	☐ Yes
Case Conferencing	You, or one of the health professionals involved in your care, may ask your ITC Provider or GP to arrange a case conference. Case conferences provide an opportunity for you and the people who provide medical and other services to meet and plan your future care.	☐ Yes
My Health Record	Clinical ITC staff directly involved in your care may request to view and upload health information into your My Health Record. Your verbal consent will need to be provided each time this needs to occur. It is possible to set up privacy settings within My Health Record to receive a text whenever your record is accessed; or to limit access to only those whom you have provided a passcode.	☐ Yes
Home Medication Review	A Home Medication Review (HMR) may be recommended to assist in the management of your ongoing medication needs. This will require release of your medical and medication history, as well as Medicare Number to the pharmacist. The pharmacist will communicate the findings of the HMR to you and your ITC Provider.	☒ Yes ☒ No
Review of ITC Registration	Your ITC needs and ability to self-manage will be reviewed regularly. You may be discharged from the program as you become better able to self-manage. Should your needs change in the future your GP can submit a new ITC referral.	☐ Yes
Discrimination	The ITC Program prohibits discrimination based on age, race, gender identity, sexuality, religious or political beliefs or activity or other characteristics possessed or assumed as protected under Federal and State anti-discrimination law.	☐ Yes
Program Reporting and Evaluation	I understand that the ITC Program is funded by the Australian Government, and that de-identified statistical information will be collected and used to assist in ITC Program reporting and evaluation. This will help ensure continuous ITC Program improvement.	☐ Yes

Client Name:	Signature:	Date:
.....		
Parent/Guardian/Carer Name:	Signature:	Date:
.....		
ITC Staff Member Name:	Signature:	Date:
.....		

ITC Program Verbal Consent:

Verbal consent should only be used where it is not practicable to obtain written consent

I have discussed the above information with the client and/or the parent/guardian and am satisfied that they understand the proposed collection, use and disclosure of personal health information and have provided informed consent to participate in the ITC Program.

ITC Staff Member's Name:	Signature:	Date:
.....		



Attachment to
Chronic Disease Management Plan / GPMP for ITC

Patient Name: _____

Patient ID: _____

Date of Birth: _____

This document forms part of the Chronic Disease Management Plan completed on: _____
Date

Referral to Allied Health *(Please ensure a Medicare Referral has also been completed)*

- ☐ Physiotherapist
- ☐ Podiatrist
- ☐ Diabetic Educator
- ☐ Dietician
- ☐ Other (e.g ITC Program) _____

Referral to Specialist

- ☐ General Surgeon
- ☐ ENT
- ☐ Cardiologist
- ☐ Other _____

Patient requires the following medical aids:

- ☐ Assisted Breathing Equipment
- ☐ Blood Sugar/ Glucose Monitoring Equipment
- ☐ Dose Administration Aid
- ☐ Medical Footwear (Prescribed by a Podiatrist) And Orthotics
- ☐ Mobility Aids
- ☐ Spectacles
- ☐ Exceptional Circumstances _____

Please specify the exact aid required and explain how this request relates to their chronic condition: *ie: Webster pack for medication compliance*

Completed by: (GP)

Date: