| DOB |  | | | | PID Number |
| --- | --- | --- | --- | --- | --- |
| Gender |  | | | |  |
| Title |  | | | Surname |  |
| Given Names | | |  | | |
| Address | |  | | | |
|  | | *(Type or affix sticker)* | | | |

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| **Referral source** | | | |
| **General Practitioner (Name):** | | **LHD (Name):** | |
| **Allied Health:** | | **Self-referral:** | |
| **Other:** | | | |
| **Initial reason for referral:** | | **Referral date:** select date | |
| GP Name: | | Practice Name: | |
| Email: | Telephone: | | Alternate GP: |

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| **Patient Details** | |
| Family Name: | Given Names: |
| Address: | Suburb: |
| Medicare Number: | D.O.B (Date of birth): |
| Mobile no.: | Home phone: |
| Email: | Does the patient live alone?  Yes  No |
| Preferred Language: | Interpreter required:  Yes  No |
| Have a Health Care Card?  Yes  No | Is the patient a main carer?  Yes  No |
| Does the patient have a partner?  Yes  No | If yes, partners full name: |
| Does the patient have a carer?  Yes  No | If yes, carers full name: |
| If yes, is the carer related?  Yes  No | Partner or Carers contact phone number: |
| Is the patient Aboriginal or Torres Strait Islander? (Please tick one of the following)  Aboriginal  No  Torres Strait Islander  Not stated  Both Aboriginal and Torres Strait Islander  Does not identify | |

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| **Referral Details** | | |
| **Chronic Disease details**/: (Please tick all that apply) | | |
| Patient has Arthritis  Patient has Asthma  Patient has Back Pain  Patient has Cardiovascular Disease | Patient has Cancer  Patient has Chronic Kidney Disease  Patient has COPD  Patient has Diabetes | Patient has Osteoporosis  Patient has Mental Health Condition  Other: |

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| **Current Chronic Disease Management – Patient has** (Please tick all that apply)  GP Management Plan (GPMP item 721 / review item 732) AND  Aboriginal and Torres Strait Islander Peoples Health Assessment (item 715)  Team Care Arrangements (item 723 / review item 732) OR  Mental Health Treatment Plan (item 2700, 2701, 2715 or 2717 / review item 2712 or 2713)  Health Assessments (item 701 / item 703 / item 705 / item 707)  **Note: Please attach a copy of the relevant care plan/s to this form.** |

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| The patient is considered to have limited access to multidisciplinary care from allied and other health professionals due to: (Please tick all that apply)  Financial Barriers  Health/Medical Barriers  Geographical Barriers (>100km from service provider)  Transport/Physical Access Limitations  Social/Cultural Barriers  English not First Language  Patient has exhausted Medicare CDM Allied Health Visits |

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| **Additional Information** (relevant medical history or impairment or complexity) |
| **Supporting Comments:** |
| **The above patient has given consent to be contacted by the SE NSW Chronic Care Coordination program** |

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| **Patients Eligibility and Exclusions** |
| * Community based * Have a chronic medical condition and complex care needs * Eligible for GP management Plan (GPMP – item 721 or 715) * Eligible for Aboriginal and Torres Strait Islander Peoples Health Assessment (item 715) * Eligible for Team Care Arrangements (TCA – item 723) * Aged 18 and over, or 15 and over for Aboriginal and Torres Strait Islander * Consented to referral |
| **Exclusions**   * Reside outside of South Eastern New South Wales * Permanent residents of RACF​ * Medicare ineligible ​ * DVA Cardholders​ |

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| **Tips for completing the Referral form** |
| * Ensure the patient has a handout explaining the Chronic Care Coordination program * Ensure that the patient has access to a telephone by including all phone numbers in **patient details section** * Need to ensure a copy of the relevant care plan/s to this form:   + GP Management Plan (GPMP item 721 / review item 732) AND   + Aboriginal and Torres Strait Islander Peoples Health Assessment (item 715)   + Team Care Arrangements (item 723 / review item 732) OR   + Mental Health Treatment Plan (item 2700, 2701, 2715 or 2717 / review item 2712 or 2713) * Need to ensure a medical summary is included in the **Additional information section** or as an attachment * Please advise in the **supporting comments section** if the patient is involved with:   + Social prescribing   + ITC   + Specialist care service   + Palliative Care |
| **Further Information** |
| For all general enquires please contact Ph: 1300 650 803 or email: [SENSW@silverchain.org.au](mailto:SENSW@silverchain.org.au)  Silverchain Group <https://silverchain.org.au/>  COORDINARE South Eastern Primary Health Network <https://www.coordinare.org.au/>  Health Pathways link: <https://www.coordinare.org.au/for-health-professionals/system-integration/healthpathways/> |