**Support for Aboriginal and Torres Strait Islander people with chronic health conditions to better manage their condition and connect to health and community services**

***Please fax referral form and a copy of GP Management Plan (08) 8312 2506****No access to a fax please phone (08) 8643 5600*

|  |  |
| --- | --- |
| **Name of GP** |  |
| GP Practice & Address  |  |
| Phone |  | Fax |  |

 **Patient Details**

|  |  |
| --- | --- |
| Full name on Medicare card |  |
| Preferred name (s) |  | Date of Birth |  |
| Email |  | Gender |  |
| Mobile: Other Phone: Are there any restrictions regarding how or when we contact you?:  |
| Address Residential: Postcode:  |
| Address Postal: Postcode:  |
| Medicare Number |  | CRN |  |
| Name of Emergency contact person: \_ \_\_\_\_ \_\_\_ Phone: \_\_\_\_\_\_ Consent to share information: Yes ☐ No ☐ Pronoun your emergency contact uses for you (e.g. he/him, she/her, them/them): |

**Client Eligibility**

|  |  |
| --- | --- |
| Does the patient identify as:[ ]  Aboriginal[ ]  Torres Strait Islander[ ]  Both Aboriginal and Torres  Strait Islander | Does the client have a care plan? [ ]  Yes [ ]  No*(If yes, please send with referral)* |
| Has the client had an Aboriginal Health Assessment (item 715) [ ]  Yes [ ]  No |
| Has the client been identified as having a Chronic Disease? [ ]  Yes [ ]  No |
| Has the client given CONSENT for this referral? [ ]  Yes [ ]  No |

**Please indicate which of the following Chronic Disease/s the client has** (tick more than one if applicable)**:**

[ ]  Cancer[ ]  Diabetes [ ]  Cardiovascular Disease

[ ]  Chronic Kidney Disease **** [ ]  Chronic Respiratory Disease

**Please indicate the reason for referral:**

|  |  |
| --- | --- |
| [ ]  Chronic Disease Management: | [ ]  Transport to Medical Appointments: |
| [ ]  Approved Medical Aids: (*Glasses, assisted breathing equipment, podiatry approved shoes, dose administration aids, blood sugar monitoring equipment, mobility aids, shower chairs)* |

**GP Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Referring GP)

**Date:** \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_