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