 Integrated Team Care Referral Form

**Please email referral and ALL documentation to:** **intake@cobh.org.au**

**Referral date** ……/…../……… (Referral is valid for 12 months)

# Client eligibility

**Does the client identify as Aboriginal and/or Torres Strait Islander?** Aboriginal [ ]  Torres Strait Islander [ ]  Both [ ]

**Does the client have a current 715 ATSI Health Check?** Yes [ ]  No [ ]  Unsure [ ]

**Does the client have a current GP Management Plan? (721)**

Yes [ ]  (If yes, please attach) No [ ]  **(If no, client is not eligible)**

**The client has a significant chronic disease** (tick one or more as appropriate, referrals must relate to a chronic disease)

[ ] Diabetes

[ ]  Cardiovascular disease

[ ]  Cancer

[ ]  Chronic respiratory disease

[ ]  Chronic renal disease

[ ]  Other chronic disease

**Has the client given CONSENT for this referral?** [ ]  Yes [ ]  No

# Client details

**Surname:** ………………………………………………..**First name:** ………………………………………………………

**Date of birth** ……/…../……… **Gender:** Male [ ]  Female [ ]  Other [ ]

**Residential address (including postcode):**……………………………………………………………………………….

……………………………………………………………………………………………………………………………………

**Home phone number:**…………………………………………….**Mobile number:**………………………………………

**Medicare Number:**…………………………………………………**CRN:**………………………..

**Please indicate the reason for referral:**

[ ]  Chronic Disease Management: [ ]  Travel Assistance (For Chronic Disease) [ ] Approved Medical Aids:

**What the ITC Program can cover:**

* Medical specialist and allied health services fees, where these services are not otherwise available in a clinically acceptable timeframe.
* Assisted breathing equipment (asthma spacer, nebuliser, CPAP machines, accessories for CPAP machines). Blood glucose monitoring equipment (excludes continuous glucose monitoring devices)
* Dose administration aids
* Medical footwear (prescribed and fitted by a podiatrist)
* Mobility aids (crutches, walking frames, non-electric wheelchairs, shower chairs)
* Spectacles (ITC team member must be present at optometrist appointment. $250 available once every two years unless there has been a significant change within the two years)

# Referring GP details

**Name:**

**Phone number:** **Fax:**

**Practice name:**

**Practice street address:**

**Please attach Support Letter and GP Management Plan (MBS Item 721) with ITC Referral**

**Note: Services NOT covered include medication costs, dental, operations or hospital stays and transport**

# Please provide a brief summary of what support the client requires:

|  |
| --- |
|  |

**Care Coordination**

**Client requires Care Coordination:** Yes [ ]  No [ ]  **Level of assistance:** Low [ ]  Medium [ ]  High [ ]

**Has the client been referred to any other services?**

NDIS [ ]  Aged Care [ ]  Other [ ]  :………………………………………………………………………………………….

**I have discussed the proposed referral to the ITC Program with the client and I am satisfied that the client**

**understands and is able to provide informed consent to this.**

Referring GP’s signature: ………………………………………………. GP name:…………………………………………

Date: ……/…../………

**DISCLAIMER: Approval of the Support Services requested will be on a priority basis and contingent on staff capacity and available funding.**