A couple of black and green logos

Description automatically generated with medium confidence Integrated Team Care Referral Form

**Please email referral and ALL documentation to:** [**intake@cobh.org.au**](mailto: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.**