GP Referral Form

WAPHA Aboriginal Health

WA Integrated Team Care Program

The Integrated Team Care (ITC) Program supports Aboriginal and Torres Strait Islander people with complex chronic care needs to improve self-management of their condition in partnership with their GP. See HealthPathways for further information.[v]

Referring GP Details: (stamp accepted)	
Name:	
Practice:	
Practice Address:	
Phone: Fax:	

Patient Details:	
First Name:	Date of Birth:
Surname:	Phone:
Residential Address:	Postcode:
Next of Kin/Alternate Contact:	Alternate Contact Phone:

My patient fulfils ALL the criteria below:

- ☐ Is Aboriginal and/or Torres Strait Islander
- ☐ Has chronic health needs requiring complex and/or multidisciplinary care
- ☐ Is enrolled for Chronic Disease Management (CDM) with their GP - *select relevant and attach plans with referral*
  - ☐ a) **preferred:** Has a **GP Management Plan MBS721**[i]**;** and/or
  - ☐ b) Team Care Arrangements MBS723; or has
  - ☐ c) current Aboriginal Health Check MBS715 and is registered for PIP IHI for CDM with referring practice[ii]; or
  - ☐ d) is being referred by non-usual GP or Remote Area Nurse (RAN) with an interim[iii] CDM care plan.

Note: referral options b) - d) must provide a GP Management Plan MBS721 within three months.

Chronic Condition Details *(tick as applicable to patient)*

- ☐ Diabetes
- ☐ Cardiovascular disease
- ☐ Cancer
- ☐ Other[iv] – specify:
- ☐ Eye health condition associated with diabetes
- ☐ Chronic kidney disease
- ☐ Chronic respiratory disease

Is another organisation already currently providing Care Coordination? If yes, specify:

.....

Eg. Aboriginal Community Controlled Health Service; ICDC Program. Provide Client ID Number if available.

NDIS and Aged Care:

Is the client registered for NDIS:	☐ Yes	☐ No	☐ In progress
Is the client registered for Aged Care support:	☐ Yes, Level: N/A	☐ No	☐ In progress

Reason/s for ITC Referral:[v]

☐ Requires Supplementary Services support ☐ Requires Care Coordination support

THE ITC PROGRAM IS ONLY ABLE TO PROVIDE SUPPORT RECOMMENDED IN THE GP CARE PLAN AND NOT AVAILABLE THROUGH OTHER MEANS.

Provide brief detail as per care plan:

.....

.....

Eg. Ulcerated foot. Request Medicare Gap payment support for 2 x Podiatrist services. Upcoming appointment 18/4/18.

Patient Information and Consent

My GP has explained the purpose of this referral for the ITC Program; I give permission for my care plan to be shared with the ITC Provider; and for the ITC Provider to contact me to discuss how the ITC Program can support me in my care plan needs.

Patient signature:[vi] GP signature:[vii]

Verbal consent (where signature not practicable) ☐ [vi] Date:

Forward completed ITC Referral Form, patient care plan and other relevant documents to ITC Provider

See below for examples of potential ITC support.
Include ALL relevant recommendations in care plan.

Requested Care Coordination support could include:	
Help client arrange appointments for chronic condition management	*Eg. GPMP Reviews with usual GP, diagnostic tests, pharmacy review, allied health and specialist visits.* *Forward all relevant documents with WA ITC Referral Form:* • *Copy of GP Care Plan;* • *Upcoming appointment dates* • *Team Care Arrangements;* • *Allied Health Medicare CDM Referral Form;* • *Allied Health Medicare Referral Form (linked to MBS715);* • *Copy of named/preferred provider referral forms*
Clinical service	*Eg. Clinical observations (BMI, BP, etc), health promotion, contribute to care planning, condition monitoring, self-management support.*
Case Conferencing/Management	*Eg. Support practice staff to arrange case conferencing; participate in case conferencing and team care.*
Attend initial appointments with client	*Eg. Support client to become comfortable in new clinical setting, overcome language barriers, understand clinical language; provide cultural brokerage.*
Provide client education on chronic condition/s and care plan	*Eg. Medication, treatment regimen*
Link client with general wellbeing and holistic care support	*Eg. Women's/men's support groups, social and emotional wellbeing support, cultural healing.*
Arrange transport for access to chronic condition management appointments	*Where the client doesn't already have access to alternative transport.*

Requested Supplementary Services support could include:	
Provide financial assistance to enable access to approved medical equipment	*Eg. Approved aids include: Assisted breathing equipment, blood sugar/glucose monitoring equipment, dose administration aids, medical footwear as prescribed and fitted by podiatrist, mobility aids, spectacles. Note: Requests for CPAP require Sleep Study and trial of CPAP before ITC support to access CPAP can be considered.*
Provide financial assistance to enable access to specialist/allied health professional services	*Where it has been indicated that patient is financially unable to access clinically necessary services for the management of their chronic condition; and/or patient has exhausted available Medicare Allied Health items.*
Provide transport for access to chronic condition management appointments	*Where the client doesn't already have access to alternative transport.*

THE SUPPORT RECOMMENDED WILL BE ASSESSED BY A CARE COORDINATOR AND APPROVED BASED ON CLIENT NEED AND PROGRAM CAPACITY.

FORWARD REFERRAL TO APPROPRIATE ITC REGION – see HealthPathways[v] for Provider details *ITC Providers will forward referrals received for clients of other ITC regions to the correct ITC Provider*	
Perth Metro – North West, South East, Inner Metro	Perth Metro – North East, South West
Perth Metro – South West	Kimberley
Pilbara	Goldfields
Midwest - North	Midwest - South
Wheatbelt – Coastal, Eastern, Western Wheatbelt	South West
Wheatbelt – Southern Wheatbelt	Great Southern

[i] *Or equivalent from a Health Care Home practice*

[ii] *Must be registered for the component of PIP IHI for patients with a chronic condition – not for PBS CoPayment alone.*

[iii] *GP or RAN may submit an interim care plan (eg. carried out during a long consult) for patients without access to their usual GP. The plan must be comprehensive, relevant to client's CDM, and include recommended ITC support.*

[iv] *As per the MBS, an eligible condition is one that has been, or is likely to be, present for at least six months*

[v] *See ITC HealthPathways for further information – https://wa.healthpathways.org.au/65938.htm?zoom_highlight=integrated+team+care++itc, (username: connected; password: healthcare).*

[vi] *Verbal consent should only be used where it is not practicable to obtain written consent*