Great Southern Integrated Chronic Disease Care Program

REFERRAL FORM *(for Program enquiries phone 9842 2797)*

General Practitioner or Nurse Practitioner details

Name: Phone:

Practice: Email:

Practice address: Fax:

Allied Health or Nurse Referrer if applicable *(please also include patients GP details)*

Name: Email:

Practice: Phone:

Patient details

Name: Home / Work Phone:

Address: Mobile Phone:

Date of Birth: / / Medicare #: Ref #:

Patient Identifies as: ☐ Aboriginal or ☐ CALD Health Care Card #:

Referring practitioner, please tick relevant boxes in each section below

ELIGIBILITY FOR ICDC PROGRAM – (MUST BE TICKED)

☐ **Health care card** ☐ **Low income earner** ☐ **Social disadvantage**

Eligibility criteria may not apply if no private allied services are available in patient's location.

Chronic Diseases:

☐ **Diabetes**	Diagnosed: _____	☐ at high risk of
☐ **Respiratory**	Diagnosed: _____	☐ at high risk of
☐ **Cardiac Conditions**	Diagnosed: _____	☐ at high risk of
☐ **Complex Comorbidities**		

Current Chronic Disease Management: (a copy of the relevant **care plan to be attached** to this form)

☐ Patient has GP Management Plan (item 721 / review item 732) AND
☐ Team Care Arrangements (item 723 / review item 732) OR
☐ GP has contributed to/reviewed multidisciplinary care plan from patient's aged care facility (item 731)

Allied Health Services Recommended or to be considered: (Group programs also available)

☐ Care Coordination / Support ☐ Exercise Program/ Physiologist ☐ Respiratory Physiotherapist
☐ Diabetes Educator ☐ Dietitian ☐ Podiatrist ☐ COPD /Asthma Educator

Some allied health services not available in all locations. Services dependent on availability.

Reasons for referral: (Please also attach a patient health summary)

This program aims to improve the health of vulnerable, disadvantaged or otherwise eligible individuals. This service is fully funded. The patient gives consent to be contacted by the ICDC Care Coordinator to discuss allied health care, including telehealth services where appropriate.

Patient signature /agreement: _____ Date: _____

Referrer signature: _____ Date: _____

Send referral forms to Amity Health - fax: 9842 2798 or email: query@amityhealth.com.au

Amity Health acknowledges WA Primary Health Alliance (WAPHA) for providing funding in its role as the operator of the Country WA PHN
http://www.wapha.org.au