Greater Western Aboriginal Health Service

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WELLINGTON ABORIGINAL CORPORATION HEALTH SERVICE
ICN: 792

Integrated Team Care Program: Referral Form

Program Eligibility

Patient identifies as Aboriginal and/or Torres Strait Islander:

- ☐ Aboriginal;
- ☐ Torres Strait Islander;
- ☐ Both Aboriginal and Torres Strait Islander.

Supporting Documentation: Please ensure all documents are included with referral

- ☐ 715 Aboriginal and Torres Strait Islander Health Assessment
- ☐ 721/723 Chronic Disease GP Management Plan and Team Care Arrangement
- ☐ Other

Patient has one or more of the chronic conditions listed below:

- ☐ Diabetes
- ☐ Cancer
- ☐ Chronic renal disease
- ☐ Cardiovascular disease
- ☐ Chronic respiratory disease
- ☐ Eye health condition associated with diabetes
- ☐ Mental health condition

Patients Details

First Name: _____ **Surname**: _____ **D/O/B:** _____

Address: _____ **Contact Number**: _____

Medicare Card: _____ **Exp**: ____ **Health Care:** _____ **Exp**: ____

Does the patient have a carer? _____ **Does the patient or carer have access to a vehicle?** _____

Emergency Contact & Number: _____

GP: _____ **Practice Name**: _____ **Contact**: _____

Reason for Referral:

Specialist/Allied Health Funding: **Payment of relevant specialist and or allied health appointments.**	

Medical Equipment: **Must be prescribed, recommended by GP/Specialist/allied health professional; See Medical and Mobility Aids Checklist below.**	
Care Coordination: **Support for patients with chronic conditions to access relevant ITC services.**	

Medical and Mobility Aids Checklist	Yes	No	Comments
Has the aid been recommended by a GP, Specialist or allied health professional as part of the patient's care plan?			
Are the supporting recommendation, care plan documents attached?			
Has the patient had an assessment and an education session regarding their ability to use and care for the aid?			
Has the GP, Specialist or allied health professional provided details regarding the type of medical and/or mobility aid required?			

Referrer Details

Name/Organisation: _____ Signature: _____ Date: _____

Patient Consent

Client's Name: _____ Carer's Name: _____

Client/Carer's Signature: _____ Dated: _____

PLEASE EMAIL ALL REFERRALS AND ATTACHMENTS TO ITC@GWAHS.NET.AU

Office Use Only

Attachments received: ☐ Yes ☐ No- action required **Referral meets eligibility**: ☐ Yes ☐ No

Patient/referrer informed of outcome:

☐ Yes

Manager approval: ☐ Yes ☐ No **Worker Assigned: _____**

Communicare File: ☐ Yes ☐ No- created date: _____ **Manager sign off: _____**