Chronic Disease Management Program (CDMP)
GP Referral Form

Program eligibility:		
Does this person identify as: ☐ Aboriginal ☐ Torres Strait Islander ☐ Aboriginal & Torres Strait Islander		
The patient has completed a health assessment (MBS 715) in the last 9-12 months	☐ Yes ☐ Is copy of completed health assessment attached?	☐ **No – a care plan and health assessment are required for access to this program**
The patient has a current (within previous 6-12 months) GP Management Plan and Team Care Arrangement	☐ Yes ☐ Is a copy of the completed GPMP/TCA attached?	
The patient's chronic disease type/s *(tick one or more as appropriate)*	☐diabetes ☐cardiovascular disease ☐cancer ☐chronic respiratory disease ☐chronic renal disease ☐other (please specify) _____	

PIP-IHI Information:		
This practice is participating in the Practice Incentive Program–Indigenous Health Incentive (PIP-IHI)	☐ Yes	☐ No
This patient is PIP-IHI registered	☐ Yes	☐ No
This patient is Closing The Gap (CTG) registered	☐ Yes	☐ No

Referring GP details:			
Name			
Phone number		Email	
Practice name			
Practice street address			
Referral date	_ _ _ / _ _ _ / _ _ _		

Patient details:			
Surname		First Name	
Gender	☐ Male ☐ Female	Date of Birth	_ _ _ / _ _ _ / _ _ _
Residential address			
Phone number			
Patient Observations *(within the last 2 months)*	Height:_____ Weight: _____ Waist: _____ BMI: _____ BP: _____ Pulse: _____ HbA1c: _____ ACR: _____ eGFR: _____		
The reason my patient requires **Care Coordination** services *(tick 1 or more as appropriate)*	☐ is at significant risk of experiencing otherwise avoidable (lengthy and/or frequent) hospital admissions ☐ is at risk of inappropriate use of services, such as hospital emergency presentations ☐ is not using community based services appropriately or at all		

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	☐ needs help to overcome barriers to access services ☐ requires more intensive care coordination than is currently able to be provided by general practice/Indigenous Health Service staff ☐ is unable to manage a mix of multiple community based services ☐ other _____
Reason patient requires **Supplementary Services** (i.e. medical specialist/allied health/local transport services in accordance with the care plan *(tick 1 or more as appropriate)*	☐ to address risk factors, such as a waiting period for a service longer than is clinically appropriate ☐ to reduce the likelihood of a hospital admission ☐ to reduce the patient's length of stay in hospital ☐ as not available through other funding sources ☐ to ensure access to a clinical service that would not be accessible because of the cost of a local transport service ☐ other_____
Referral authorised by: GP name, signature and stamp	
Date	_ _ _ / _ _ _ / _ _ _

My GP or Care Coordinator has discussed the Program Fact Sheet with me. I understand what I have been told, any questions I had about the Program have been satisfactorily answered and I now want to participate.

- I understand that my participation is voluntary and that I have the right to withdraw from the Program at any time.
- I understand that a range of health and community service providers may collect, use and disclose my relevant personal information as part of my care.
- I understand that the personal information collected by these organisations will be maintained consistent with National Privacy Principles. It will remain confidential except when it is a legal requirement to disclose information; or where failure to disclose information would place me or another person at risk; or when my written consent has been obtained to release the information to a third party.
- I understand that statistical information (that will not identify me) will be collected and used to see how well the Program is working and help improve services for Aboriginal and Torres Strait Islander people.

Patient Name and Signature:	**Name:** **Signature:**
Date:	_ _ _ / _ _ _ / _ _ _

I have discussed the proposed referral to Care Coordination / Supplementary Service with the patient and am satisfied that the patient understands and is able to provide informed consent to this.

GP/Care Coordinator name and signature:	**Name:** **Signature:**
Date:	_ _ _ / _ _ _ / _ _ _

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