NCACCH Service Access Form

Patient Name:			**DOB:**
NCACCH HAC Number:	**EXT:**	**Medical Record Number**: (if applicable)	
Closing The Gap PBS claimed: (all Aboriginal and/or Torres Strait Islander patients):			
Closing The Gap IHI claimed: (Aboriginal and/or Torres Strait Islander patients over 15 with a chronic condition)			
General Practitioner:		**Date Attended:**	

Tick the following boxes below relevant to the patients' presentation

CLINICAL INFORMATION	**ADULT HEALTH** (15+ years of age)	**CHILD HEALTH** (0-14 years of age)
Cardiac	☐	☐
Dermatology	☐	☐
Endocrine	☐	☐
ENT	☐	☐
Full Adult/Child Health Check (715)	☐	☐
Gastro-Intestinal	☐	☐
Influenza	☐	☐
Immunization	☐	☐
Mental Health	☐	☐
Musculo-Skeletal	☐	☐
Pregnancy	☐	☐
Renal	☐	☐
Respiratory	☐	☐
Sexual/Reproductive	☐	☐
Other: *please provide details*		
Chronic Condition	Yes ☐ No ☐	Yes ☐ No ☐
Acute Episode	Yes ☐ No ☐	Yes ☐ No ☐
Is the patient a smoker?	Yes ☐ No ☐	**Result of ear examination?**
		Normal ☐
If no:	☐ Never Smoked ☐ Ex-Smoker	Abnormal ☐
		N/A ☐

MBS Item claimed				

Request Referral to NCACCH HealthTrax Chronic Disease Management Program	☐

Patient Consent:

To assist NCACCH in continuing to deliver quality health care, I agree for my GP to share relevant information with NCACCH. I understand the information will be treated in strict confidence and will not be used for any other purpose that is not related to NCACCH services.

Signature: