NCACCH | North Coast Aboriginal Corporation for Community Health

# NCACCH Service Access Form

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|---|---|---|---|
| **Practice:** | | | |
| **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 | ☐ | ☐ |
| Aboriginal & Torres Strait Islander Health Check (715) | ☐ | ☐ |
| Health Assessment (701 – 707) | ☐ | ☐ |
| 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** | | | | |

**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:**