NCACCH
North Coast Aboriginal Corporation for Community Health

Chronic Disease Management Program (CDMP) GP Referral

Program Eligibility			
Does this patient identify as: ☐ **Aboriginal** ☐ **Torres Strait Islander** ☐ **Aboriginal & Torres Strait Islander**			
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/stamp			
Name			
Phone number		Email	
Practice name			
Practice street address			
Referral date	_ _ _ / _ _ _ / _ _ _		
Patient Eligibility			
The patient has a current Health Check (MBS 715) in the last 9-12 months	☐ Yes ☐ Please attach a copy with this referral.	☐ **No** **A Current Care Plan (721,723 or 732) and a 715 Health Check are required for access to this program.**	
The patient has a current GP Management Plan and Team Care Arrangement (MBS 721,723 or 732 within previous 6-12 months)	☐ Yes ☐ Please attach a copy with this referral.		
The patient's chronic disease type/s *(tick one or more as appropriate)*	☐ Diabetes T1/T2 ☐ Cardiovascular Disease ☐ Chronic Respiratory Disease (COPD, Severe Asthma, Sleep Apnoea) ☐ Chronic Renal Disease ☐ Cancer ☐ Other (please specify) _____		
Patient details			
Surname			
First Name			
Gender	☐ Male ☐ Female ☐ Other	Date of Birth	_ _ _ / _ _ _ / _ _ _
Residential address			
Phone number			

Patient Observations *(within the last 2 months)*	Weight: _____ Height: _____ Waist: _____ BMI: _____ BP: _____ Pulse: _____ HbA1c: _____ ACR: _____ eGFR: _____
Care Coordination	
Does the patient require Care Coordination	☐ Yes ☐ No
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 ☐ 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
Supplementary Services	
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_____

Patient requires funding assistance for:

For the patient to receive funding support from NCACCH CDMP, we require a GPMP/TCA (721/723/732) every 6-12 months and a 715 Health Check every 9-12 months

UPON REGISTRATION THE BELOW MAY BE FUNDED BY CDMP PROGRAM*

☐ External Allied Health gap fee assistance (when all Care plan and 715 Allied Health visits have been utilised)
- **requires prior CDMP approval**

☐ External Specialist gap fee assistance (referral pathway to HHS to be accessed first)
- **requires prior CDMP approval**

☐ Radiology procedure gap fee assistance (Bulk billing providers to be utilised first)
- **requires prior CDMP approval**

☐ Transport assistance (if not avaliable through QAS, PTSS, Aged Care Providers or Taxi Subsidy) not for GP appointments, Allied Health and Specialist's only. **Minimum 3 days notice required**

☐ CPAP Equipment Diagnostic & Tritation results must meet the QLD Health criteria of AHI >30 & ESS 10+/24

☐ Orthotics & Medical grade footwear

☐ Mobility Aids – walking sticks, 4WW, shower chairs, non-electric wheelchair

☐ Other (discretionary funding may be avaliable) – Please specify _____

☐ Dose Administration Aids (Packing fees only)

☐ Asthma/respiratory related equipment

***Please consider all other funding sources**

- MASS - Medical Aids Subsidy Scheme Continence aids, Spectecles
- PTSS - Patient Transport Subsidy Scheme
- QAS - Queensland Ambulance Service
- Aged Care Funding including CAPS packages and transport
- NDIS - National Disability Insurance Scheme
- Australian Diability Parking Permit
- QLD Government Taxi Subsidy Scheme
- Centrelink Essential Medical Equipment payment (electricity subsidy for running medical equipment ie CPAP, nebuliser, home dialysis etc)

Please note: SPECIFIC EXCLUSIONS NOT COVERED BY CDMP FUNDING include:

- Medication
- Nutritional Supplements
- Wound care items including dressings
- Treatment procedures
- Surgery
- Hospitialisation
- Vital Call personal alarms
- Dental services
- Equipment maintenance
- Major home modifications
- Motorised mobility aids

Referral authorised by: **GP name, signature and stamp**	
Date	_ _ _ / _ _ _ / _ _ _

Patient Consent

My GP or Care Coordinator has discussed the CDMP 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.

CASE CONFERENCE CONSENT

You or one of the professionals involved in your care, can ask your Care Coordinator or GP to arrange a case conference at anytime. Case conferences provide an opportunity for you and the people who provide medical and other services can meet and plan and assist in your future care.

The Health Care team including the Care Coordinator will arrange a case conference upon registration of all new clients to CDMP to discuss required services and Care Coordination.

You are encouraged to attend case conferences but can choose not to or you may send someone on your behalf. A record will be kept in your medical notes and discussed with you and (if appropriate and with your consent) your carer. ☐ I consent to have my medical team to arrange a case conference to assist with my health management.

Patient Name:	
Date:	_ _ _ / _ _ _ / _ _ _
Signature:	

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.

Referring GP Signature:	
Date:	_ _ / _ _ _ / _ _ _
Signature:	

PLEASE NOTE:

This referral will not be accepted if not completed and/or signed by the GP and Patient.

If you have any questions regarding this referral, please contact the CDMP Team on 5346 9800 for support and fax completed CDMP GP Referral to 5335 1272 or email cdmpsupport@ncacch.org.au