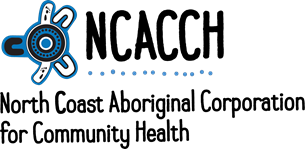
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**Chronic Disease Management Program (CDMP) GP Referral**

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| **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 gap fee assistance (Bulk billing providers to be utilised first)  - **requires prior CDMP approval**  Transport assistance (if not available 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 & Titration results must meet the QLD Health criteria of AHI >30 & ESS 10+/24  Orthotics & Medical grade footwear (upon Podiatrist recommendations)  Mobility Aids – walking sticks, 4WW, shower chairs, non-electric wheelchair (upon Physiotherapy and/or Occupational Therapists Recommendations)  Other (discretionary funding may be avaliable) – Please specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Asthma/respiratory related equipment  **\*Please consider all other available funding sources**   * MASS - Medical Aids Subsidy Scheme Continence aids, Spectacles * 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 * Hospitalisation * 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.

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| --- | --- |
| **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 [mandy@ncacch.org.au](mailto:mandy@ncacch.org.au)