MACKAY
F: (07) 4421 7450
P: (07) 4898 2700

TOWNSVILLE
F: (07) 4421 7450
P: (07) 4421 7700

OFFICE HOURS Monday to Friday 8.30am – 4.30pm

Referral Form
Care Coordination and Supplementary Services

If you consider this referral a high priority please call our office after faxing the referral

Eligibility

This practice participates in the Practice Incentive Program - Indigenous Health Incentive (PIP-IHI) Yes ☐ No ☐

This patient is PIP-IHI registered Yes ☐ No ☐

This patient has an Indigenous health check and care plan
Yes *(please attach copy)* ☐
No *(If no, this person is not eligible for the CCSS program)* ☐

☐ Diabetes

☐ Cardiovascular Disease

☐ Chronic Renal Disease

☐ Chronic Respiratory Disease

☐ Cancer

Persons Details

First Name | Surname

DOB | Gender

Address | Postcode

Phone (work) | Phone (home) | Mobile

Indigenous Status | Interpreter Required Yes ☐ No ☐

Medicare Card # | Ref # | Expiry | Health Care Card # | Expiry

Applicable Private Health Insurance? Yes ☐ No ☐

Contacts (Complete relevant field/s)

Can we contact these people if we are unable to contact the referred person to schedule an appointment Yes ☐ No ☐

Next of Kin/ Emergency Contact:

Name | Phone

Address | Postcode

Relationship to person:

Carer Details: (if applicable)

Name | Phone

Referrer Details (if applicable)

Name

Organisation

Address | Postcode

Fax | Provider Number

Referral Information

Reason for Referral

Diagnosis

Allergies

Current Medications (Please attach medications summary)

Relevant medical history/conditions (Please attach health summary)

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

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

Consent to referral:
My GP has discussed the CCSS 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 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.

Referred person/ Carer name	
Signature:	

I have discussed the proposed referral to the CCSS Program with the person and/or their guardian and am satisfied that the person and/or their guardian understands and is able to provide informed consent to this referral

Referrer's signature: _____

Referral Date:

Please attach copy of current ATSI Health Check (MBS 715)

Northern Australia Primary Health Limited
ABN: 87063397231
www.naphl.com.au