General Practitioner Referral Form

Closing the Gap – Care Coordination and Supplementary Services (CCSS) Program

Program eligibility:		
This patient has an Indigenous health check (715)	☐ Yes	☐ **No** (if no, this patient is not eligible for the CCSS program)
This patient has a care plan	☐ Yes	
The patient's chronic disease type/s *(tick one or more as appropriate)*	☐diabetes ☐cardiovascular disease ☐cancer ☐chronic respiratory disease ☐chronic renal disease	

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
Referral date:	_ _ _ / _ _ _ / _ _ _

Referring GP details:			
Name			
Phone number		Email	
Practice name			
Practice street address			
Source of referral	☐ General practice	☐ Community-Controlled Health Service	

Patient details:			
Surname		First name	
Date of birth	_ _ _ / _ _ _ / _ _ _		
Gender	☐ Male ☐ Female	Medicare Number (if available)	
Residential address *(including postcode)*			
Phone number			
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		

	☐ other _____ _____	
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 _____ _____ _____	☐ **None required at present**
Referral authorised by: GP name, signature and stamp		
Date	_ _ _ / _ _ _ / _ _ _	

Patient information and consent

My GP or Care Coordinator 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 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.

Patient name and signature	**Name**	**Signature**
Date	_ _ _ / _ _ _ / _ _ _	

I have discussed the proposed referral to the CCSS Program with the patient and am satisfied that the patient understands and is able to provide informed consent to this.

GP/Care Coordinator name and signature	**Name**	**Signature**
Date	_ __ / _ _ _ / _ _ _	