

Integrated Team Care (ITC) General Practitioner Referral Form Care Coordination and Supplementary Services

The ITC program provides assistance for Aboriginal and Torres Strait Islanders with chronic health problems who require help in coordinating their healthcare and/or require help in accessing services and medical aids not available through other funding sources, or not without lengthy delays.

Re-enrolment is required at the commencement of each calendar year for ongoing services.

Client eligibility

Does the client identify as Aboriginal and/or Torres Strait Islander?

Aboriginal Torres Strait Islander Both

If yes, client is eligible for Outreach Worker Services:

Transport GP support Social support

Does the client have a current 715 ATSI Health Check?

Yes (*If yes, please attach*) No (*If no, client is not eligible*)

Does the client have a current GP Management Plan and Team Care (721+723)?

Yes (*If yes, please attach*) No (*If no, client is not eligible*)

The client has a significant chronic disease (tick one or more as appropriate)

Diabetes Cardiovascular disease Cancer

Chronic respiratory disease Chronic renal disease Other chronic disease

If other, please specify:

Referring GP details

Name: _____

Phone number: _____ **Fax:** _____

Practice name: _____

Practice street address: _____

Source of referral: General practice Community-Controlled Health Service

Please fax this form to: (07) 3205 8666 or Email: ITC@iuih.org.au

Client details

Surname: _____ **First name:** _____

Date of birth: _____

Gender: Male Female Other

Residential address (including postcode): _____

Home phone number: _____ **Mobile number:** _____

Care Coordination¹

Client requires care coordination: Yes No

Level of assistance: Low Medium High

Anticipated duration: Short (<6 mths) Medium (6-12 mths) Long term (>12 mths)

Supplementary Services²

Client requires funding assistance:

- | | |
|--|--|
| <input type="checkbox"/> Allied health fee gap assistance | <input type="checkbox"/> Specialist fee gap assistance |
| <input type="checkbox"/> Radiology procedure fee gap assistance | <input type="checkbox"/> Transport subsidy (including parking fees and cab vouchers) |
| <input type="checkbox"/> DAA (Dose administration aids including Webster Packing) | <input type="checkbox"/> CPAP equipment |
| <input type="checkbox"/> Nebuliser & other asthma-related equipment (<i>Where possible, spacers should be used rather than nebulisers</i>) | <input type="checkbox"/> Orthotics & footwear |
| <input type="checkbox"/> Mobility aids (e.g. walking frames, or non-electric wheel chairs) or shower chairs. | <input type="checkbox"/> Glucometer & diabetes-related equipment |
| | <input type="checkbox"/> Spectacles |
| | <input type="checkbox"/> Other (specify): Click here to enter text. |

Note: services NOT covered include medication costs, dental, operations or hospital stays.

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Consider other funding sources, including:

- MAAS (Medical Aids Subsidy Scheme) – eg: continence aids
- NDSS (National Diabetes Subsidy Scheme) – eg: insulin needles
- QAS (Queensland Ambulance Service) – eg: clinic cars
- Aged Care funding, including CAPS packages – eg: Vital Call, Aged Care transport
- QUMAX Funding – eg: DAA, glucometers, sphygmometers, spacers, certain medications, testing lancets)
- Australian Disability Parking Permit
- QLD Government Taxi Subsidy Scheme
- Centrelink Essential Medical Equipment payment – electricity subsidy for running medical equipment such as CPAP, home dialysis, nebuliser etc

Consent form

(Mark box if consent is given)

ITC CCSS PROGRAM 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.

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 any time. Case conferences provide an opportunity for you and the people who provide medical and other services to meet and plan your future care.

The health care team including Care Coordinator will arrange a case conference upon enrolment of all new clients to ITC 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 agreement) your carer.

- I consent to my medical team arranging a case conference regarding my health management.

HOME MEDICATION REVIEW (HMR) CONSENT

- I consent to having a Home Medication Review (HMR).
- I regularly attend _____ pharmacy in _____
- I consent to the release of my medical history and medication to the pharmacist.
- I understand the pharmacist will conduct the HMR and communicate to me information arising from the HMR.
- I consent to the release of my Medicare Number to the pharmacist for the pharmacist's payment purposes.

Client signature and consent: _____

Client name: _____

Date: _____

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

Referring GP's signature: _____

GP name: _____

Date of referral: _____

Care Coordinator signature: _____

Name of Care Coordinator: _____

Date: _____

Notes

¹Care Coordination Criteria

Client:

- 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
- is unable to manage a mix of multiple community-based services.

²Supplementary Services Criteria

- 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 client'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.

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**Any questions regarding this referral, please
call the ITC hotline on
1800 254 354**