



## General Practitioner Referral Form

Program eligibility:			
This practice is participating in the Practice Incentive Program– Indigenous Health Incentive (PIP-IHI)	<input type="checkbox"/> Yes		<b>☐ No – do not proceed with this referral as the patient is not eligible for this Program</b>
This patient is PIP-IHI registered	<input type="checkbox"/> Yes		
This patient has a care plan	<input type="checkbox"/> Yes		
The patient's chronic disease type/s (tick one or more as appropriate)	<input type="checkbox"/> diabetes <input type="checkbox"/> cardiovascular disease <input type="checkbox"/> cancer <input type="checkbox"/> chronic respiratory disease <input type="checkbox"/> chronic renal disease <input type="checkbox"/> other _____		
<b>Referral date:</b>	___ / ___ / ___		
Referring GP details:			
Name			
Phone number		Email	
Practice name			
Practice street address			
Source of referral	<input type="checkbox"/> General practice	<input type="checkbox"/> Community-Controlled Health Service	
Patient details:			
Surname		First name	
Date of birth	___ / ___ / ___ (patient must be 15 years or over)		
Gender	<input type="checkbox"/> Male <input type="checkbox"/> 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)	<input type="checkbox"/> is at significant risk of experiencing otherwise avoidable (lengthy and/or frequent) hospital admissions <input type="checkbox"/> is at risk of inappropriate use of services, such as hospital emergency presentations <input type="checkbox"/> is not using community based services appropriately or at all <input type="checkbox"/> needs help to overcome barriers to access services <input type="checkbox"/> requires more intensive care coordination than is currently able to be provided by general practice/Indigenous Health Service staff <input type="checkbox"/> is unable to manage a mix of multiple community based services <input type="checkbox"/> other _____		

Reason patient requires Supplementary Services (i.e. medical specialist/allied health/local transport services in accordance with the care plan <i>(tick 1 or more as appropriate)</i> )	<input type="checkbox"/> to address risk factors, such as a waiting period for a service longer than is clinically appropriate <input type="checkbox"/> to reduce the likelihood of a hospital admission <input type="checkbox"/> to reduce the patient's length of stay in hospital <input type="checkbox"/> as not available through other funding sources <input type="checkbox"/> to ensure access to a clinical service that would not be accessible because of the cost of a local transport service <input type="checkbox"/> other _____	<input type="checkbox"/> <b>None required at present</b>
Referral authorised by: GP name, signature and stamp		
Date	___/___/___	

**Patient information and consent**

<p>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.</p> <ul style="list-style-type: none"> <li>• I understand that my participation is voluntary and that I have the right to withdraw from the Program at any time.</li> <li>• 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.</li> <li>• 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.</li> <li>• 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.</li> </ul>	
Patient name and 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	
Date	___/___/___