Integrated Team Care Program

General Practitioner Referral Form

INTEGRATED TEAM CARE PROGRAM

The ITC program helps with Aboriginal and Torres Strait Islanders diagnosed with chronic health conditions who require help in coordinating their healthcare and/or require help in accessing services and relevant medical aids not available through other funding sources i.e., NDIS, or not without lengthy delays.

Client Name		**Date of Birth**	
Gender		**Contact Number**	
Residential Address			
Contact Email			

Complete Mamu Health Service Limited Patient Registration Form and attach.

Non-Clients of Mamu Health Service Limited are not eligible for Mamu Health Service Limited's Transport Service.

Consider other funding sources in the first instance, including:

- MAAS (Medical Aids Subsidy Scheme) – e.g.: continence aids
- NDSS (National Diabetes Subsidy Scheme) – e.g.: insulin needles
- QAS (Queensland Ambulance Service)
- Aged Care funding, including CAPS packages – e.g.: Vital Call, Aged Care transport.
- QUMAX Funding – e.g.: DAA, glucometers, sphygmomanometers, 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.

Has the client applied for any of the above services?
◯ Yes **(Provide proof of application with outcome)**
◯ No **(Seek other funding first)**

Is the client on the waiting list for any of the above services?
◯ Yes – Which service?
_____
◯ No **(The client must use the waitlist for a minimum of 6 months initially.)**

Does the client have private health insurance?
◯ Yes – **(Client not eligible)**
◯ No

Client Eligibility

Indigenous identification:
◯ Aboriginal
◯ Torres Strait Islander
◯ Both

Current GP Management Plan and Team Care (721+723):
◯ Yes (Please attach)
◯ No **(Client not eligible)**

Current 715 ATSI Health Check:
◯ Yes (Please attach if available)
◯ No
◯ Unsure

Chronic Disease/s relevant to the ITC referral:
◯ Diabetes
◯ cardiovascular disease
◯ Cancer
◯ Chronic respiratory disease
◯ Chronic renal disease
◯ Other (Specify): _____

Referring General Practitioner Details

GP Name			(OR STAMP)
Practice Name			
Practice Address			
Phone		**Fax**	
Email			

MHSL Office Use Only

ITC Referral Received Date	*721/723 Date*	*732 Date*	*ITC Assessment Date*	*ITC Enrolment Date*	*ITC Discharge Date*

Phone Call Consent Date				*Tier Allocation*	*1*	*2* *3*

Care Coordination & Supplementary Services	
Level of Care Coordination assistance required	◯ Low ◯ Medium ◯ High
Anticipated duration of support. *New referral is required 12 months after enrolment date.*	◯ Short (Less than 6 months) ◯ Medium (6-12 months) ◯ Long term (12+ months)

Specify any supplementary services required, considering other funding sources:

◯ **Allied health fee gap assistance**
◯ **Radiology procedure fee gap assistance**
◯ **DAA**
(Dose administration aids including Webster Packing)
◯ **Nebuliser & other asthma-related equipment** (Where possible, spacers should be used rather than nebulisers)
◯ **Mobility aids** (eg. walking frames, non-electric wheelchairs or shower chairs.)
◯ **Specialist fee gap assistance**
◯ **Transport subsidy** (including parking fees and cab vouchers)
◯ **CPAP equipment** (Not including replacements within 12 months)
◯ **Orthotics & footwear** (Not including replacements within 12 months)
◯ **Glucometer & diabetes-related equipment**
◯ **Spectacles** (Cannot fund if received from ITC in past)

Note: Services NOT covered include medication costs, dental, operations or hospital stays and GP appointment transport.

Describe the care coordination and supplementary service's needs:

Client Consent

Program Consent

I, the undersigned, have been briefed on the ITC Program by my GP or ITC Officer. I comprehend the details provided, and any queries I had about the Program have been satisfactorily addressed. I willingly opt to enrol in the ITC Program.

- I understand that my enrolment is voluntary, and I reserve the right to withdraw from the Program at any time.
- I understand that various 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 consistently with National Privacy Principles. It will remain confidential except when legally required to disclose information, or when failure to disclose information would pose a risk to me or another person, or when my written consent has been obtained to release information to a third party.
- I understand that statistical information (that will not identify me) will be collected and used to assess the effectiveness of the Program and improve services for Aboriginal and Torres Strait Islander people.

Client Signature		**Date**	

Case Conference

I, the undersigned, grant consent for my medical team to arrange a case conference regarding my health management.
You, or one of the professionals involved in your care, can request the ITC Program Team to organise a case conference at any time. Case conferences provide an opportunity for you and the healthcare professionals to meet and plan your future care.

- The ITC Team will arrange a case conference if required, depending on your level of assistance.

- 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.

Client Signature		Date	

Home Medication Review (HMR) Consent

I, the undersigned, consent to having a Home Medication Review (HMR).

- I regularly attend (Pharmacy)_____
- I consent to the release of my medical history and medication to the pharmacist.
- I understand that 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		Date	

Referring GP Checklist

(!) Ensure all supporting documents are attached to complete this referral.
For example, the podiatrist report recommending orthotics, the dietitian report recommending Resource etc.

Have you attached?

◯ Copy of Care Plan (GPMP/TCA)
◯ Allied Health report detailing recommendations for the supplementary services requested
◯ Copy of 715 health check
◯ Specialist report detailing recommendations for the supplementary services requested

Email referral and all documentation to

itc@mamuhsl.org.au

Referrals without the attached documentation will be rejected.

The referral will be assessed, and feedback will be provided on the outcome of the referral.
Please allow up to 5 working days for this to process.