ITC REFERRAL ELIGIBILITY ASSESSMENT

To be completed by ITC Coordinator

UNGOOROO ABORIGINAL CORPORATION

Client Name :_____ **Has the appropriate Care Plan been attached to referral?** ☐ Yes (if yes, tick documents supplied) ☐ No (if no, client is not eligible)	☐ 715 Health Assessment *(a must have)* ☐ GPMP ☐ TCA ☐ MHCP ☐ Referral for Sleep Study OR ☐ Current report (if applicable) ☐ OT assessment OR ☐ Referral to OT (if applicable) ☐ Referral to Psychiatrist/ Psychologist OR ☐ Report (if applicable) ☐ Referral to Podiatrist OR ☐ Report (if applicable)	
Does the client identify as:	☐ Yes - Aboriginal and/or Torres Strait Islander ☐ No - not eligible	
Does the client have an eligible chronic disease type(s) which require high complexity and care coordination support: ☐ Yes – tick appropriate item from right column ☐ No – Why? *Follow up with referring GP.*	☐ Diabetes ☐ Cardiovascular Disease ☐ Chronic Kidney Disease ☐ Respiratory / COPD / Asthma (Sleep study report required) ☐ Cancer (Type if known: _____) ☐ Mental Health Condition ☐ Other Condition: _____	
Other Reasons for Referral:	☐ Care Coordination ☐ Assistance with Specialist ☐ Assistance with Allied Health ☐ Assistance with Medical Aids (complete Medical Aids Checklist below) ☐ Other: _____	
Medical Aids:	*(Only complete if indicated from referral)*	
Has the aid been recommended by a GP, Specialist or Allied Health Professional as part of the patients plan?	☐ Yes ☐ No	Comments:
Prior to Purchasing, has the client had an OT Assessment with a recommendation of type of medical aid to purchase?	☐ Yes ☐ No	Comments:
Other information if relevant		
Assessment Completed by:		
Date:	**Signature:**	