ITC: Complex Chronic Care Coordination Referral Form

UNGOOROO ABORIGINAL CORPORATION

Provide the listed documents with this referral to enable assessment of your patient's eligibility for complex care coordination program. **Without the documentation your patient will be ineligible.** *(Please supply - other relevant supporting documentation such as referrals or reports to/from Sleep Study / Psychiatrist/ Psychologist / Podiatrist / OT etc.)*	☐ GPMP only ☐ TCA if eligible ☐ MHCP only - for mental health diagnosis. (**Please note:** if ineligible for GPMP, a Mental Health Care Plan must be provided) (***Must** have a current 715 Health Assessment completed and attached)*
The patient identifies as:	☐ Aboriginal and/or Torres Strait Islander
The eligible chronic disease type(s) which require high complexity and care coordination support:	☐ Diabetes ☐ Cardiovascular Disease ☐ Chronic Kidney Disease ☐ Respiratory / COPD / Asthma ☐ Cancer (Type if known: _____) ☐ Mental Health Condition
Referral Date:	Preferred Practice Contact: ☐ GP ☐ Practice Nurse
Referring GP Details:	Affix stamp here if applicable
Name:	
Phone No:	
Practice Name and Street Address:	
GP Name & Signature: **Date:**	
Reason for Referral:	

PATIENT DETAILS	
First Name:	**Surname:**
DOB:	**Gender:** ☐ **Male** ☐ **Female** ☐ **Other:** _____
Medicare No:	**Residential Address:**
Phone No:	
Please email completed form to itc@ungooroo.com.au	