INTERGRATED TEAM CARE PROGRAM (ITC) REFERRAL FORM

Please Note: Not all clients with a chronic condition received need assistance through the ITC program.
For the purpose of the ITC Program all referrals will be triaged and prioritised accordingly.

DETAILS OF PERSON					
Has the person agreed to this referral?			Yes	No	
(Please Note: referrals will not be accepted without the consent of the person)					
Is the person Aboriginal or Torres Strait Islander?			Yes	No	
(Please Note: this program is for Aboriginal and Torres Strait Islander people only)					
First Name:			Surname:		
Date of Birth:		Age	Male	Female	Other
Address:				Postcode:	
Phone:			Mobile:		
Email:					
Which contact/s would the person prefer to use?			Home	Mobile	Email
Does the patient have a Carer?			Yes	No	
Does the patient or Carer have access to a vehicle?			Yes	No	
Medicare No:		Reference No:		Expiry Date:	
Healthcare Card No				Expiry Date:	

Emergency Contact			
First Name:		Surname:	
Relationship to Person:			
Address		Postcode:	
Phone:		Mobile:	
Email:			

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GP INFORMATION

Does The Person Have A Regular GP?	Yes No
GP Name:	
GP Phone Number:	
Name of Practice:	
Address of Practice:	

PROGRAM ELIGIBILITY

Patient identifies as Aboriginal and/or Torres Strait Islander: Aboriginal Torres Strait Islander Both

Patient has one or more of the chronic conditions listed below:

Diabetes	Chronic Renal Disease	Chronic Respiratory Disease	Eye health condition associated with Diabetes
Cancer	Cardiovascular Disease	Mental Health	

Other please specify:

SUPPORTING DOCUMENTATIONS: Please ensure all documents are included with referral

715 Aboriginal and Torres Strait Islander Assessment

721/723 Chronic Disease GP Management Plan and Team Care Arrangement

Other please specify:

REASON FOR REFERRAL

CARE COORDINATION: Support for patients with chronic conditions to aces relevant ITC services	
ASSISTANCE WITH: Specialists/Allied Health	
ASSISTANCE WITH MEDICAL EQUIPMENT: Must be prescribed, recommended by GP/ Specialist/Allied health professionals; See Medical and Mobility Aids Checklist below	
OTHER:	

INTERGRATED TEAM CARE PROGRAM (ITC)
REFERRAL FORM

MEDICAL AND MOBILITY AIDS CHECKLIST

Has the aid been recommended by a GP, Specialist or Allied Health Professional as part of the patients plan?

Yes No Comments

Are the supporting recommendations, care plan documents attached?

Yes No Comments

Has the patient had an assessment and an education session regarding their ability to use and care for the aid?

Yes No Comments

Has the GP, Specialist or Allied Health Professional provided details regarding the type of medical and/or air required?

Yes No Comments

DETAILS OF REFERRER

Name of Referrer:			
Organisation:			
Signature:		Date:	

STAFF USE ONLY

Referral received on At time: By:

Attachments received: Yes No Referral meets eligibility: Yes No

Prioritisation: Low Medium High Patient/Referrer informed of outcome: Yes No

Additional Notes:

Please fax or email referral to: **UNGOOROO ABORIGINAL CORPORATION** | PHONE: 6571 5111
EMAIL: itc@ungooroo.com.au | FAX: 6571 5777