ITC: Complex Chronic Care Coordination Referral Form

Provide the listed documents with this referral to enable assessment of your patient's eligibility for complex care coordination program. **<u>Without the documentation your patient will be ineligible.</u>** *<u>(Please supply - other relevant supporting documentation such as referrals or reports to/from Sleep Study / Psychiatrist/ Psychologist / Podiatrist / OT etc.)</u>*	☐ 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*** also 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

Name:	**Phone No:**
Practice Name:	**Address:**
Signature:	**Date:**

Reason for Referral:

_____

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PATIENT DETAILS

First Name:	**Surname:**
DOB:	**Gender:**
Medicare No: **Ref#:** **Expiry date:**	**Residential Address:**
Phone No:	**Other contact if applicable:**

Please email completed form to itc@ungooroo.com.au