| DOB |  | | | | PID Number |
| --- | --- | --- | --- | --- | --- |
| Gender |  | | | |  |
| Title |  | | | Surname |  |
| Given Names | | |  | | |
| Address | |  | | | |
|  | | *(Type or affix sticker)* | | | |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Client details** | | | | | | |
| **Name** |  | | | | | |
| **Address** |  | | | | | |
| **Medicare number** |  | | | **Date of Birth** | |  |
| **Healthcare card number**  Yes No |  | | | **Ethnicity** | |  |
| **Language** | |  |
| **Identify as** | Aboriginal  Torres Strait Islander  Both  Neither | | | | | |
| **Gender** | Male  Female  non-Binary  Other | | | | | |
| **NOK/ emergency contact** |  | | | | | |
| **Contact number** |  | | **Relationship** | |  | |
|  | | | | | | |
| **General Practitioner Information** | | | | | | |
| **Primary GP name** |  | | | | | |
| **Medical centre** |  | | | | | |
| **Contact number** |  | | | | | |
| **Introducing Community organisation** | | | | | | |
| **Organisation** |  | | | | | |
| **Main contact person** |  | | | | | |
| **Contact number** |  | | | | | |
| **Email** |  | | | | | |
| **Consent to contact**  Yes  No | | | | | | |
| **Reason for seeking support** | | | | | | |
|  | | | | | | |
| **Chronic health condition** | | | | | | |
|  | | | | | | |
| **Mental health conditions**  **N/A** | | | | | | |
|  | | | | | | |
| **Alcohol and other drugs.** **N/A** | | | | | | |
| Alcohol use?  Yes  No | | Does this concern you  Yes  No | | | | |
| Drug use?  Yes  No | | Does this concern you  Yes  No | | | | |
| Please describe: | | | | | | |

|  |  |  |
| --- | --- | --- |
| **Community organisations** | | |
| Does the client currently access any other community services? | | |
| Organisation | Contact | Client Consent for CPAC to share information if required. |
|  |  | Yes  No |
|  |  | Yes  No |
|  |  | Yes No |
|  | | |

I agree to the Silverchain Care Planning and Coordination service contacting my regular GP as listed on this form for further health information and to advise of my participation in the service.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Signature Date

*For further information please call 1300 650 803 and request to speak to the Care Planning and Coordination Case Coordinator.*

|  |
| --- |
| **CPAC Staff use only** |
| Received date:  Eligible for CPAC service  Yes  No  Has GP been contacted  Yes  No  Health Summary received  Yes  No  **Mental Health Care Plan**  Does the client have a MHCP?  No  N/A  Yes Received  Yes  No  **GP Management Plan**  Does the client have a GPMP?  No  N/A  Yes Received  Yes  No  BRA complete  Yes  No |