| 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 [ ]  NoHas GP been contacted [ ]  Yes [ ]  NoHealth 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 [ ]  NoBRA complete [ ]  Yes [ ]  No |