silverchain

REFERRAL FORM
CHRONIC CARE COORDINATION

Referral Guidelines

1. Please complete all sections of this form and return to Silver Chain Group via eFax on **1300 601 788**
2. Alternatively, our referral form can be uploaded to your Practice Software and submitted via HealthLink, EDI: virginia
4. All sections are mandatory, please tick all that apply to this patient
5. For enquiries, please phone 1300 650 803

Initial reason for referral:		**Referral date:**
GP Name:	**Practice Name:**	
Email:	**Telephone:**	**Alternate GP:**

PATIENT DETAILS

FAMILY NAME:	GIVEN NAMES:	
ADDRESS:		SUBURB:
Postcode:	Medicare Number:	D.O.B
GENDER:	HOME PHONE:	MOBILE NO:
EMAIL:		Does the patient live alone? ☐Yes ☐No
Country of Birth:	Preferred Language:	Interpreter required: ☐Yes ☐ No
Does the patient work? ☐Yes ☐No	Have a Health Care Card? ☐Yes ☐ No	Is the patient a main carer? ☐Yes ☐ No
Does the patient have a partner? ☐Yes ☐No	If yes, partners full name:	
Does the patient have a carer? ☐Yes ☐No	If yes, carers full name:	
If yes, is the carer related? ☐Yes ☐No	Partner/Carers contact phone number/s:	

Is the patient Aboriginal or Torres Strait Islander?	☐ No ☐ Yes – Aboriginal ☐ Yes – Torres Strait Islander ☐ Yes – Both Aboriginal and Torres Strait Islander ☐ Declined to respond ☐ Not stated

REFERRAL DETAILS

Chronic Disease Details (Please tick all that apply):

☐ Patient has Arthritis	☐ Patient has Cancer	☐ Patient has Osteoporosis
☐ Patient has Asthma	☐ Patient has Chronic Kidney Disease	☐ Patient has Mental Health Condition
☐ Patient has Back Pain	☐ Patient has COPD	☐ Other:
☐ Patient has Cardiovascular Disease	☐ Patient has Diabetes	

Current Chronic Disease Management - Patient has (Please tick all that apply):

☐ GP Management Plan (GPMP item 721 / review item 732) AND
☐ Aboriginal and Torres Strait Islander Peoples Health Assessment (item 715)
☐ Team Care Arrangements (item 723 / review item 732) OR
☐ Mental Health Treatment Plan (item 2700, 2701, 2715 or 2717 / review item 2712 or 2713)
☐ Health Assessments (item 701 / item 703 / item 705 / item 707)

Note: Please attach a copy of the relevant care plan/s to this form.

The patient is considered to have limited access to multidisciplinary care from allied and other health professionals due to: (Please tick all that apply)

☐ Financial Barriers
☐ Geographical Barriers (>100km from service provider)
☐ Social/Cultural Barriers
☐ Patient has exhausted Medicare CDM Allied Health Visits
☐ Health/Medical Barriers
☐ Transport/Physical Access Limitations
☐ English not First Language

Additional information (relevant medical history or impairment or complexity):

Supporting Comments:

☐ **The above patient has given consent to be contacted by the Chronic Care Coordination program**

silverchain

REFERRAL FORM
CHRONIC CARE COORDINATION

Referral Guidelines

1. Please complete all sections of this form and return to Silver Chain Group via email to screferrals@silverchain.org.au
2. Alternatively, referrals can be faxed to
3. Please tick all that apply to this patient
4. All sections are mandatory fields
5. For enquiries, please phone 1300 650 803

PATIENT COHORT

People with Chronic conditions and complex care needs – items 10950 to 10970

ELIGIBILITY CRITERIA

- Community based
- Have a chronic medical condition and complex care needs
- Have a GP management Plan (GPMP – item 721 or 715)
- Have an Aboriginal and Torres Strait Islander Peoples Health Assessment (item 715)
- Eligible for a Team Care Arrangements (TCA – item 723)
- Aged 18 and over, or 15 and over for Aboriginal and Torres Strait Islander (ATSI)
- Consented to referral

Exclusions:

- Permanent residents of RACF
- Medicare ineligible
- DVA Cardholders
- NDIS clients

GUIDE TO COMPETING THIS REFERRAL FORM

*The patient must give consent to be contacted by the Chronic Care Coordination program

1. Please complete all sections of this form and return to Silver Chain Group via email to: **screferrals@silverchain.org.au**
2. Please tick all that apply to patient
3. All sections are mandatory fields
4. For enquiries, please phone **1300 650 803**

TIPS TO COMPLETE THIS REFERRAL FORM

- Ensure the patient has a handout explaining the Chronic Care Coordination program
- Ensure that the patient has access to a telephone by including all phone numbers in **patient details section**
- Need to ensure a copy of the relevant care plan/s to this form:
    - GP Management Plan (GPMP item 721 / review item 732) AND
    - Aboriginal and Torres Strait Islander Peoples Health Assessment (item 715)
    - Team Care Arrangements (item 723 / review item 732) OR
    - Mental Health Treatment Plan (item 2700, 2701, 2715 or 2717 / review item 2712 or 2713)
- Need to ensure a medical summary is included in the **Additional information section** or as an attachment
- Please advise in the **supporting comments section** if the patient is involved in the following programs:
    - Social prescribing
    - ITC
    - Pharmacy support
- Please advise in the **supporting comments section** if the patient is involved with:
    - Specialist care service
    - Palliative Care
    - Oncology

FURTHER INFORMATION

For all general enquires please contact Ph: 1300 650 803 or email: southeastnsw_carecoordination@silverchain.org.au

Silver Chain Group: https://silverchain.org.au

COORDINARE South Eastern Primary Health Network: https://www.coordinare.org.au

Health Pathways link: https://www.coordinare.org.au/for-health-professionals/system-integration/healthpathways