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REFERRAL FORM
CHRONIC CARE COORDINATION

Referral Guidelines

1. Please complete all sections of this form and return to Silver Chain Group via Healthlink EDI: **virginia**
2. Alternatively, referrals can be faxed to: 1300 601 788
3. Please tick all that apply to this patient
4. All sections are mandatory fields
5. For enquiries, please phone 1300 650 803

Referral date:	<<Miscellaneous:Date>>
PROVIDER DETAILS	
GP Name	<<Doctor:Name>>
Provider Number	<<Doctor:Provider Number>>
Practice Name	<<Practice/Location:Name>>
Practice Phone	<<Practice/Location:Phone>>
Practice Fax	<<Practice/Location:Fax>>
Alternate GP	<<If you are not the patient's main GP please name:>>
PATIENT DETAILS	
Name	<<Patient Demographics:Full Name>>
Dated of Birth	<<Patient Demographics:DOB>> (<<Patient Demographics:Age>>)
Medicare Card	<<Patient Demographics:Medicare Number>> | <<Patient Demographics:Medicare Expiry Date>>
Health Care Card	<<Patient Demographics:Health Insurance>>
Address	<<Patient Demographics:Full Address>>
Phone	**H:** <<Patient Demographics:Phone (Home)>>**M:** <<Patient Demographics:Phone (Mobile)>>
Sex | Identifies as Transgender	<<Patient Demographics:Gender>> | <<Patient Demographics:Transgender>>
Ethnicity	<<Patient Demographics:Ethnicity>>
Preferred Language	<<Patient Demographics:Language Preferred>>
Interpreter required:	<<Patient Demographics:Requires Interpreter>>
FAMILY AND SOCIAL HISTORY	
Does the patient work?	<<Patient Demographics:Occupation>>
Does the patient have a partner?	<<Patient Demographics:Marital Status>>
If yes, partners full name:	<<Patient Partners name: >>
Does the patient have a carer?	<<Does the patient have a carer?>>
If yes, carers full name:	<<If yes, what is the carers name?>>
If yes, is the carer related?	<<If yes, what is the carers relationship to the patient?>>
Partner/Carers contact phone number/s:	<<If yes, Partner/Carers contact phone number:>>
Patient consents to referral:	<<Patient consents to referral?>>
Consent to contact partner / carer?	<<Consent provided to contact partner / carer?>>
REFERRAL DETAILS	
Reason for referral:	<<Reason for Referral: >>

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Current Chronic Disease Management	<<Select all that apply: Include selected documents >> **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)	<<Related issues: Select all that apply:>>
Supporting Comments:	<<Supporting \ Other Comments?>>

MEDICAL HISTORY

History:
<<Clinical Details:History List>>

Medications
<<Clinical Details:Medication List>>

Allergies:
<<Clinical Details:Allergies/Adverse Reactions>>

Immunisations:
<<Clinical Details:Immunisation List>>

PATIENT COHORT

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

ELIGIBILITY CRITERIA

Selection 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

Exclusion Criteria:

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

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**

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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 (link: to be added)

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

RELEVANT INVESTIGATIONS

<<Summary:Investigation Results (Selected)>>