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**South East Coastal Goldfields Integrated Chronic Disease Care**

**I.C.D.C REFERRAL FORM Enquiries: 9842 2797**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **General Practitioner, Nurse Practitioner, or other health provider details** | | | | | | |
| Name: | | | | Phone: | | |
| Practice: | | | | Fax: | | |
| Practice address: | | | | Email: | | |
| **Allied Health Referrer if Applicable *(Please also complete GP details)*** | | | | | | |
| Name: | | | | Email: | | |
| Practice: | | | | Phone: | | |
| **Patient details** | | | | | | |
| Name: | | | | Home or Work phone: | | |
| Address: | | | | Mobile phone: | | |
| Date of birth: | | | | Medicare #: Ref #: | | |
| Patient identifies as:  Aboriginal or  CALD | | | | Health Care Card #: | | |
| **Referring practitioner, please tick relevant boxes in each section below** | | | | | | |
| **Eligibility** The patient must be diagnosed with at least one of the three chronic diseases (Diabetes, Resp, Cardiac) | | | | | | |
|  Health care card or financial disadvantage | | | |  Social disadvantage or Vulnerable | | |
|  Living in an area not adequately serviced | | | |  | | |
| **Barriers to accessing services may include** | | | | | | |
|  Health or medical reasons | |  Transport or physical access limitations | | | |  English not first language |
| **Chronic disease and comorbidity** | | | | | | |
| **Diabetes:** |  diagnosed…………… | | | |  |  | | --- | --- | | **Respiratory:**  diagnosed…………….. |  | | | |
| **Cardiovascular:** |  diagnosed…………… | | |  | | |
|  |  | | |  | | |
| **Current Chronic Disease Management** (if available a copy of the relevant care plan) | | | | | | |
|  Patient has GP Management Plan (item 721 / review item 732) AND | | | | | | |
|  Team Care Arrangements (item 723 / review item 732) OR | | | | | | |
|  GP has contributed to/reviewed multidisciplinary care plan from patient’s aged care facility (item 731) | | | | | | |
| **Allied health services recommended** | | | | | | |
|  Diabetes Educator | | |  Dietitian | |  COPD / Asthma Educator | |
|  Cardiac Educator | | |  Physiotherapist | |  Podiatrist | |
| **Reason for referral** (e.g. change of medication, foot ulcer, recent cardiac event, case management support) | | | | | | |
| This program aims to improve the health of vulnerable, disadvantaged or otherwise eligible individuals in the SE Coastal Goldfields region who are diagnosed with diabetes, chronic cardiac or chronic respiratory conditions. All services are fully funded. The patient gives consent to be contacted by the ICDC Care Coordinator to plan future multidisciplinary care, including telehealth services where appropriate. | | | | | | |
| Patient’s signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| Referring practitioner’s signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| **Send completed form to: Amity Health - Fax: 08 9071 6472** | | | | | | |

*Amity Health acknowledges WA Primary Health Alliance (WAPHA) for providing funding in its role as the operator of the Country WA PHN*.