

INTEGRATED TEAM CARE Client Referral and Consent Form

The Integrated Team Care Program, which incorporates the Care Coordination and Supplementary Services, **is for Aboriginal and/or Torres Strait Islander People only, who have a diagnosed Chronic Disease.**

Eligible chronic diseases are:

- Diabetes Cardiovascular disease Cancer Chronic kidney disease
- Chronic Respiratory Condition (COPD, Asthma, etc)
- Chronic mental health conditions MHCP with mental health diagnosis
Please note: If ineligible for a GPMP, a Mental Health Care Plan must be provided

Patient must have a chronic disease as mentioned above to be eligible for the program. If you don't think a patient has a chronic disease mentioned above, please contact the clinic to discuss their options.

Reason for referral:

- Assistance with managing appointments Assistance with specialist costs
- Assistance with allied health costs Other

The ITC Program is not an Emergency Response Program and is not able to assist in Acute Situations.

You and your clients must provide the ITC team with a minimum of three weeks' notice prior to all appointments and three weeks' notice if travel and/or accommodation is needed.

Each case will be assessed on the information provided and the level of support will be determined on a case-by-case basis subject to Hunter New England Central Coast Primary Health Network (HNECC PHN) guidelines.

At times of high demand, a wait list will be created. The referrer and patient will be notified of this.

At any stage the client can request to be removed from this program by notifying the ITC staff.

Privacy and confidentiality:

Registration will allow the ITC team to access and share necessary health information with health providers and other relevant service providers who are identified to support the clients health outcomes.

All information shared between the client and HealthWISE will be treated as strictly confidential at all times.

All data collected for reporting purposes with HNECC will be de-identified.

Checklist - please attach the below documents:

- GP Management Plan. *If a patient does not have a current GPMP, please book them in for one and tell us when it will be completed. Please still send this referral and then the GPMP when completed.*
- 715 or patient health summary
- Relevant pathology
- Relevant specialist/allied health correspondence

updated May 2024

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Is the client Aboriginal? Yes No Is the client Torres Strait Islander? Yes No

You must identify with your regular General Practice as Aboriginal and/or Torres Strait Islander, and be receiving ongoing care for the diagnosed chronic disease in accordance with the Department of Health guidelines to be eligible for assistance from this program.

Client's first name	<input type="text"/>	Client's last name	<input type="text"/>	
Date of birth	<input type="text"/> / <input type="text"/> / <input type="text"/>	Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Prefer not to say	
Street address	<input type="text"/>		Town	<input type="text"/>
Post Code	<input type="text"/>	Contact phone number	<input type="text"/>	
Regular GP	<input type="text"/>	Practice name	<input type="text"/>	
Medicare card number	<input type="text"/>	Expiry Date	<input type="text"/> / <input type="text"/>	
Concession card number	<input type="text"/>	Expiry Date	<input type="text"/> / <input type="text"/>	
Concession card type	<input type="text"/>			

I hereby agree to my, or my child/ward's record being kept in a secure medical software program of HealthWISE. I acknowledge the purpose of holding this information is to assist in the management of my, or my child/ward's chronic disease/s and used for de-identified reporting to the HNECC PHN. I understand that my health condition/s may be accessible to health service providers involved in my, or my child/ward's care.

I, (full name) have read and understood the above Consent Form. I agree to these conditions for the service provided by HealthWISE for myself, OR my child/ward

Signature Date / /

OR
The client has given verbal consent to these conditions and for HealthWISE to provide services to them or their child/ward.

Name

Signature Date / /

Please send completed and signed form with a current GPMP and any current referrals to specialists to integrated.team.care@healthwise.org.au or please call for further information.

Tamworth	P: 6766 1394	F: 6766 1372
Narrabri	P: 6792 5514	F: 6792 5518
Armidale	P: 6771 1146	F: 6771 1170
Moree	P: 6752 7196	F: 6752 6616

OFFICE USE ONLY

Informed Consent Explained to Client GPMP Attached PROM 1 Completed Agreed PREM Date / /

