

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.**

Please select clients diagnosed Chronic Disease from the list below:

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 GPCCMP, a Mental Health Care Plan must be provided

Checklist - please attach the below documents:

GP Chronic Condition Management Plan
Specialist/allied health referrals and/or reports
715/Health Summary

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 two weeks' notice prior to all appointments especially when travel and/or accommodation is required.

Each case will be assessed on the information provided. 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.

HealthWISE has a zero tolerance policy for abusive behaviour. Any breaches of behaviour towards staff or service providers for this program, may result in your patient being released from this program.

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.

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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.

Full name _____ Date of birth / /

Gender Male Female Non Binary Pronouns

Address

Town Post Code Phone number

Regular GP Practice name

Medicare card number Expiry Date /

Concession card number Expiry Date /

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 form and required documents to integrated.team.care@healthwise.org.au

Tamworth	P: 6766 1394	F: 6766 1372
Narrabri	P: 6792 5514	F: 6792 5518
Armidale	P: 6771 1146	F: 6771 1170
Gunnedah	P: 6742 3633	F: 6742 3699

OFFICE USE ONLY

Informed Consent Explained to Client GPMP Attached

