COONAMBLE ABORIGINAL HEALTH SERVICES LTD

Corporate Services:
17-19 Castlereagh St Coonamble NSW 2829 **Postal:** PO Box 36 Coonamble NSW 2829
P: 02 6822 0000 **F:** 02 8016 0805 **ABN:** 26 826 765 257

GP REFERRAL AND CONSENT FORM

Banma-li Integrated Team Care (ITC) Program
Coonamble – 02 6822 0000
Gilgandra – 02 6837 5111
Dubbo – 02 6884 7502
Please email referral to Banma-li@ctgservices.com.au

Patient Details:	
First Name:	Surname:
DOB:	Address:
Phone:	Emergency Contact:

Practice Details
Practice name:
Address:
Phone:
Email:
Fax:
Referring GP name:

My client fulfils ALL the criteria below;
☐ Is Aboriginal, or Torres Strait Islander. Or Aboriginal and Torres Strait Islander ***(We REQUIRE confirmation of Aboriginality)***
☐ Has chronic and complex health needs and requires multidisciplinary care
☐ Has a current GP Management Plan & Team Care Arrangement **(please attach copy)**
☐ Has given verbal or written consent to be contacted by ITC coordinator to discuss participation in the ITC program

Chronic Disease Details (tick ALL applicable to client)
☐ Diabetes
☐ Cardiovascular Disease
☐ Chronic Kidney Disease
☐ Chronic Respiratory Disease
☐ Liver Disease
☐ Cancer

NDIS and Aged Care
Is client registered with NDIS: ☐ Yes ☐ No ☐ In Progress
Is Client registered for Aged Care Support: ☐ Yes Level: 1 2 3 4 ☐ No ☐ In Progress

Reason/s for ITC referral:
☐ Requires Supplementary Services support ☐ Client has exhausted medicare CDM Allied Health visits
☐ Requires Care Coordination support

Client Information and Consent
My GP has explained the purpose of this referral for the ITC program; I give permission for my GP management plan to be shared with the ITC coordinator, to contact me to discuss how the ITC program can support me in my care plan needs. I give permission for the ITC coordinator to exchange my information in the form of verbal, written and electric to other agencies for the purpose of care coordination.

Client/Parent or Carer Signature:

☐ _____

Verbal Consent (where signature not practical (eg: telehealth consult)

GP Name/Signature:

_____

Date:

SPECIALIST AND ALLIED HEALTH APPOINTMENT DETAILS
Specialist Name:
Specialist Address:
Specialist Phone Number:
Appointment Date:

Specialist Name:
Specialist Address:
Specialist Phone Number:
Appointment Date:

Specialist Name:
Specialist Address:
Specialist Phone Number:
Appointment Date:

Specialist name:
Specialist Address:
Specialist Phone Number:
Appointment Date:

Specialist name:
Specialist Address:
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Appointment Date:

Specialist name:
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Appointment Date: