silverchain

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: 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:	<TodaysDate>
PROVIDER DETAILS	
GP Name	<DrName>
Provider Number	<DrProviderNo>
Practice Name	<DrProviderNo>
Practice Phone	<LocationName>
Practice Fax	<LocationFax>
Alternate GP	<Is there an alternate GP for this patient? If so please provide their name:>
PATIENT DETAILS	
Name	<PtFullName>
Dated of Birth	<PtDoB> (<PtAge>**)**
Medicare Card	<PtMCNo> (<PtMCLine>) | <PtMCExpiry>
Health Care Card	<PtOccupation>
Address	<PtAddress>
Phone	**H:** <PtPhoneH> **M:** <PtPhoneMob>
Sex | Gender	<PtSex> | <GenderIdentity>
Ethnicity	<PtEthnicity>
Preferred Language	**Error! Hyperlink reference not valid.**
Interpreter required:	<Does the patient require an interpreter?>
FAMILY AND SOCIAL HISTORY	
Does the patient work?	<PtOccupation>
Does the patient have a partner?	<Does the patient have a partner?>
If yes, partners full name:	<If yes, partners full name:>
Does the patient have a carer?	<Does the patient have a carer?>
If yes, carers full name:	<If yes, carers full name:>
If yes, is the carer related?	<If yes, is the carer related?>
Partner/Carers contact phone number/s:	<Partner/Carers contact phone number/s:>
Patient consents to referral:	<Patient consents to referral?>
Consent to contact partner / carer?	<Consent to contact partner / carer?>
REFERRAL DETAILS	
Reason for referral:	<Reason for Referral?>
Current Chronic Disease Management	<Select all that apply: Include selected documents with referral> **Note: Please attach a copy of the relevant care plan/s to this form.**
The patient is considered to	<The patient is considered to have limited access to multidisciplinary care

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have limited access to multidisciplinary care from allied and other health professionals due to: (Please tick all that apply)	from allied and other health professionals due to: (Please tick all that apply)>
Supporting Comments:	<Supporting Comments:>

MEDICAL HISTORY

History:
<SelectedPMH>

Medications
<SelectedRx>

Allergies:
<Reactions>

Immunisations:
<Imm>

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

GUIDE TO COMPETING THIS REFERRAL FORM

*The patient must give consent to be contacted by the Chronic Care Coordination program

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TIPS TO COMPLETE THIS REFERRAL FORM

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- 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 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

<Ix>