CAPE YORK INTEGRATED TEAM CARE (ITC) REFERRAL FORM

Private and Confidential

Referring GP	
Name:	Provider No.:
Phone:	Fax:
Email:	
Contact Address:	

Client Details	
Name:	Medicare No.:
Residential Address:	
DOB:	Gender: ☐ Male ☐ Female ☐ Other
Home Phone:	Mobile:
Referral Date:	

Eligibility Criteria

Client identifies as: ☐ Aboriginal ☐ Torres Strait Islander ☐ Both Aboriginal & Torres Strait Islander

Client has chronic condition/s: ☐ Cancer ☐ Diabetes ☐ Cardiovascular Disease ☐ Chronic Kidney Disease ☐ Mental Health Condition ☐ Chronic Respiratory Disease ☐ Other:_____

One or more of the following apply to this client:

- ☐ Complex care needs requiring more intensive care coordination than clinic staff can provide
- ☐ At risk of avoidable or lengthy hospital admissions or inappropriate use of services (eg ED presentations)
- ☐ Appropriate community-based services not available or not meeting needs
- ☐ Needs help to manage multiple appointments or access multiple services
- ☐ Needs help to overcome barriers to accessing services
- ☐ Needs help to adhere to management and medication routines
- ☐ Needs help to develop self-management skills
- ☐ Would benefit from help to purchase medical aids or services identified in their chronic condition care plan that are not funded elsewhere or can't be accessed locally in a timely manner *AND* meet ITC guidelines

  Note: Item/s requested under supplementary services funding must be included in management/treatment plan. This can be a general reference, eg 'Podiatry treatment, and equipment as prescribed' would cover request for medically indicated shoes.

Accompanying documentation	**Date completed**	**Available in Apunipima Best Practice?**
Consent form [APU 1896] (mandatory)		☐ Yes ☐ No – copy attached
General Practice Management Plan [MBS 721] *OR* Team Care Arrangement [MBS 723] *OR* GP Mental Health Treatment Plan [MBS 2700, 2701] (at least one is mandatory)		☐ Yes ☐ No – copy attached
Aboriginal Health Check [MBS 715]		☐ Yes ☐ No – copy attached
If Aboriginal Health Check [MBS 715] is overdue, arrange for this to be actioned.		☐ Reminder in recall system

Signature (Referring GP): _____ Date: _____

Fax completed referral to Apunipima Cape York Health Council - Fax: 4038 4212 *OR* For assistance - Phone: 4037 7159

Note: Contact cannot be made with client until completed referral form, consent form, and care plan have been received.

Integrated Team Care (ITC) is an Aboriginal and Torres Strait Islander specific program funded and supported by the Australian Government Department of Health and Primary Health Networks.