

# Wheatbelt Integrated Chronic Disease Care Program



**FAX REFERRAL FORM TO HEALTH NAVIGATOR: 1300 601 788**

*GPs please note: As part of this Program, Care Coordinators support GPs to ensure patients receive timely and appropriate coordinated care and assist in the implementation of the patients care plan. This includes arranging access to face to face/telehealth services, clinical, non-clinical and self-management programs, monitoring patients progress and providing feedback to referring GP. This program aims to improve the health of vulnerable, disadvantaged or otherwise eligible individuals in the Wheatbelt. This service is fully funded.*

Patient details	
Name: <PtFullName>	Home / Work phone: <PtPhoneH>
Address: <PtAddress>	Mobile phone: <PtPhoneMob>
Date of birth: <PtDoB> Age: <PtAge>	Medicare #: <PtMCNo> Ref #: <PtMCLine>
Patient identifies as: <input type="checkbox"/> Aboriginal or <input type="checkbox"/> CALD	Health Care Card #: <PtPensionNo>
Does this patient have a carer?	<input type="checkbox"/> No <input type="checkbox"/> Yes Name:
Is there consent from client for services to contact carer?	<input type="checkbox"/> No <input type="checkbox"/> Yes Phone:
Is the client accessing: NDIS <input type="checkbox"/> My Aged Care Support <input type="checkbox"/> (add provider details if known)	
Eligibility for the program. (Please complete each section below)	
<b>Chronic disease/s (essential – please tick)</b> <input type="checkbox"/> Diabetes <input type="checkbox"/> Heart Failure <input type="checkbox"/> Cardiovascular Disease <input type="checkbox"/> COPD <input type="checkbox"/> Asthma	
<b>and/or risk factors</b> <input type="checkbox"/> Hypertension <input type="checkbox"/> Impaired Lipids <input type="checkbox"/> Impaired Glucose Regulation <input type="checkbox"/> Central Adiposity <input type="checkbox"/> List Other	
<input type="checkbox"/> Existing diagnosis <input type="checkbox"/> New diagnosis <input type="checkbox"/> High level of clinical risk	
<b>Vulnerability (essential)</b> <input type="checkbox"/> Health care card/low income earner <input type="checkbox"/> No private providers in area <input type="checkbox"/> Social disadvantage <input type="checkbox"/> Exhausted Medicare CDM allied health visits <input type="checkbox"/> Transport or physical access limitations	
<b>GP Management Plan &amp; recent pathology (essential – include medical history/health summary and medication)</b> <input type="checkbox"/> Current GP Management Plan attached (item 721 / 732) AND/OR Team Care Arrangements (item 723 / 732) <input type="checkbox"/> Recent supporting pathology attached & GP authorises release of patients pathology results to Care Coordinator	
<b>Allied health services recommended or to be considered</b> <input type="checkbox"/> COPD /Asthma Educator <input type="checkbox"/> Dietitian <input type="checkbox"/> Respiratory Physiotherapist <input type="checkbox"/> Diabetes Educator <input type="checkbox"/> Exercise Program / Physiologist <input type="checkbox"/> Podiatrist	
<i>*Allied health services not available in all locations. Services dependent on availability (these may be face to face, group programs, online or telehealth options). The client will have contacted with the recommended Allied Health professionals only if agreeable.</i>	
<b>Supporting reason for referral</b> (e.g. needs more intensive support, change of medication, foot ulcer, recent cardiac event)	
<input type="checkbox"/> Please indicate if referral needs urgent action.	
The patient has received an explanation of the ICDC program, is willing to participate and gives consent to be contacted by the Health Navigator, Amity Health or Wheatbelt Health Network Care Coordinators to plan future multidisciplinary care, including telehealth services where appropriate.	
Patient signature: _____ Date: _____	
Referrer signature, name and designation _____ Date: _____	
for Program enquiries please email <a href="mailto:healthnavigator@silverchain.org.au">healthnavigator@silverchain.org.au</a>	
General Practitioner or Nurse Practitioner details	
Name:	Phone:
Practice:	Email:

Practice address:

Fax: