MOORUNDI

Aboriginal Community Controlled Health Service Ltd.

Please Email to admin@macchs.org.au with a copy of the Care Plan, Consent Form and this Referral

Please mark as (Private and Confidential).

REFERRAL DATE: _____/_____/_____

GP DETAILS	
GP Name:	Phone:
Practice Name/Address:	Fax:

CLIENT DETAILS				
Name:	Date of Birth:		Phone:	
Address:			Gender: □ Male □ Female	
MEDICARE CARD NO:	**REF:**	**EXP:**	**CONCESSION NO:**	**EXP:**

CLIENT ELIGIBILITY		
HAS A 715 BEEN DONE **□ Yes □ No**		
Does the patient identify as; □ Aboriginal □ Torres Strait Islander □ Both Aboriginal and Torres Strait Islander	Has the client been identified as having a Chronic Disease? □ Yes □ No	
	Has the client been identified with a Chronic Mental Health concern? □ Yes □ No	
	Current GP Management Plan attached? □ Yes □ No	Current Mental Health Plan attached? □ Yes □ No
	Has the client been registered for the Practice Incentive Program (PIP) Indigenous Health Incentive (IHI)? □ Yes □ No	

Does the client have a current – Aged Care Package – YES / NO

NDIS package – YES / NO

Any other supplementary funding. YES / NO Name of organisation.....

***IMPORTANT:** If the answer to any of the above is **NO**, please contact the Care Coordinator on 1800 023 846*

Please indicate by ticking (more than one if applicable) which of the following Chronic Disease/s the client has:		
□ Cancer	□ Diabetes	□ Cardiovascular Disease
□ Chronic Kidney Disease	□ Chronic Respiratory Disease	□ Chronic Mental Health Condition
□ Other		

Care Coordination: is to help assist clients to better manage their chronic conditions, through intensive education, compliance with care plans and medication, and facilitating a range of longer term support services.

Care Coordination

- □ Care coordination ONLY
- □ Assistance with transport to medical/ allied health appointments
- □ Assistance with private medical/ allied health gap fees

Supplementary Services: this program can fund medical aids, transport costs, medical specialist & Allied health services (Gap fees) **Supplementary services are a LIMITED RESOURCE. Priority will be given to the most urgent need depending on funding**

Contact Details: Ph: 1800 023 846 Fax: (08) 70890450 Email : admin@macchs.org.au

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availability.

Medical aids

- ☐ Dose administration aides (Webster packs)
- ☐ Blood sugar/Glucose monitoring equipment
- ☐ Orthotic medical footwear (that is prescribed & fitted by a Podiatrist ONLY (Diabetics ONLY)
- ☐ Assistive breathing equipment
- ☐ Asthma Masks/Spacer
- ☐ CPAP Machines or accessories for CPAP Machines
- ☐ Spectacles
- ☐ Mobility Aides

Patient Information and Consent

My GP or care Coordinator has discussed the ITC Program with me. I understand what I have been told, any questions I had about the program have been satisfactorily answered and I now want to participate.

- Do you consent to be registered with Moorundi Aboriginal Community Controlled Health Service
- I understand that my participation is voluntary and that I have the right to withdraw from the Program at any time.
- I understand that a range of health and community service providers may collect, use and disclose my relevant personal information as part of my care.
- I understand that the personal information collected by these organisations will be maintained consistent with National Privacy Principles. It will remain confidential except when it is legal requirement to disclose information; or where failure to disclose information would place me or another person at risk; or when my written consent has been obtained to release the information to a third party.
- I understand that statistical information (that will not identify me) will be collected and used to see how well the Program is working and help me improve services for Aboriginal and Torres Strait Islander people.
- I agree the Moorundi ACCHS may access data relating to my hospital utilisation if I attended/have attended any hospital and the use of this information for research and evaluation purposes only. I am aware that this information will not refer to my private medical problems and will only relate to information relating to hospital visits and stays.
- Should I wish to access my information, a written application can be made to: Clinic Services Manager, Moorundi ACCHS, 11a Standen St, MURRAY BRIDGE, SA 5253.

Patient or parent/guardian's full name:

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Verbal consent has been given:
Date:

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Please mark as (Private and Confidential).

Signature: _____ (Referring GP) Date: ____/____/____

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