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| Referral Form for Individual Allied Health Services under Medicare for patients with a chronic medical condition and complex care needs | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Note: GPs can use this form issued by the Department of Health or one that contains all of the components of this form. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| To be completed by referring GP: Please tick: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | Patient has GP Management Plan (item 721 ) AND Team Care Arrangements (item 723) OR | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | GP has contributed to or reviewed a multidisciplinary care plan prepared by the patient’s aged care facility (item 731) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Note**: GPs are encouraged to attach a copy of the relevant part of the patient’s care plan to this form. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| GP details | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Provider Number | | | |  |  |  |  | |  |  |  | |  |  |  | |  | |  |  |  |  | |  |  |  |  | |  | | |  | | | | |  | | |  | | | | | | |
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| Name | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | |  |
|  | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
| Address | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Postcode | | |  |
| Patient details | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Medicare Number | | | |  |  |  |  | |  |  |  | |  |  |  | |  | |  |  |  |  | |  |  |  |  | |  | | | Patient’s ref no. | | | | | |  | | | Patient’s DOB.\_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_ | | | | | |  |
|  | | | |  |  |  |  | |  |  |  | |  |  |  | |  | |  |  |  |  | |  |  |  |  | |  | | |  | | | | | |  | | |  | | | | | |
| First Name | | | |  | | | | | | | | | | | | | | | | | | | | | | | | |  | | | Surname | | | | | |  | | | | | | | |  |
|  | | | |  | | | | | | | | | | | | | | | | | | | | | | | | |  | | |  | | | | | |  | | | | | | | |  |
| Address | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Postcode | | |  |
| Allied Health Provider (AHP) patient referred to: (Please specify name or type of AHP) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Name | | | | UNSW Fatigue Clinic – Exercise Physiologists | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | |
|  | | | |  | | | | | | | | | | | | | | | | | | | | | | | |  | | |  | | | | | |  | | | | | | | | | |
| Address | | | | 32 Botany St, Randwick | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Postcode 2031 | | |  |
| Referral details – Please use a separate copy of the referral form for each type of service Eligible patients may access Medicare rebates for a maximum of 5 allied health services (total) in a calendar year. Please indicate the number of services required by writing the number in the ‘No. of services’ column next to the relevant AHP. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | **No of services** | | **AHP Type** | | | | | | | | | **Item Number** | | | |  | | **No of services** | | | | | **AHP Type** | | | | | | | | | | | **Item Number** | |  | | | **No of services** | | | **AHP Type** | | | **Item Number** |  |
|  |  | | Aboriginal Health Worker/Aboriginal and Torres Strait Islander Health Practitioner | | | | | | | | | 10950 | | | |  | | 5 | | | | | Exercise Physiologist | | | | | | | | | | | 10953 | |  | | |  | | | Podiatrist | | | 10962 |  |
|  |  | | Audiologist | | | | | | | | | 10952 | | | |  | |  | | | | | Mental Health Worker | | | | | | | | | | | 10956 | |  | | |  | | | Psychologist | | | 10968 |  |
|  |  | | Chiropractor | | | | | | | | | 10964 | | | |  | |  | | | | | Occupational Therapist | | | | | | | | | | | 10958 | |  | | |  | | | Speech Pathologist | | | 10970 |  |
|  |  | | Diabetes Educator | | | | | | | | | 10951 | | | |  | |  | | | | | Osteopath | | | | | | | | | | | 10966 | |  | | | | | | | | | | |
|  |  | | Dietitian | | | | | | | | | 10954 | | | |  | |  | | | | | Physiotherapist | | | | | | | | | | | 10960 | |  | | |  | | |  | | |  |  |
|  | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | |  | | | | |  | | | | | | | | |  | | |
| **Referring General  Practitioner’s signature** | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | |  | | | | |  | | | | | | | | |  | | |
| Date signed | | | | |  | | | | | | | | |  | | |
|  | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | |  | | | | |  | | | | | | | | |  | | |
| The AHP must provide a written report to the patient’s GP after the first and last service, and more often if clinically necessary. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Allied health providers should retain this referral form for record keeping and Department of Human Services (Medicare) audit purposes. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| This form may be downloaded from the Department of Health website at [www.health.gov.au/mbsprimarycareitems](http://www.health.gov.au/mbsprimarycareitems) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **THE FORM DOES NOT HAVE TO ACCOMPANY MEDICARE CLAIMS** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

**CHRONIC DISEASE MANAGEMENT**

**COMBINED**

**PREPARATION OF A GP MANAGEMENT PLAN (GPMP) (MBS Item NO. 721) & COORDINATION OF TEAM CARE ARRANGEMENTS (MBS ITEM NO. 723)**

|  |  |
| --- | --- |
| **Date these services were provided:** |  |

|  |  |
| --- | --- |
| **Patient’s name and address:** |  |
| **Date of Birth:** |  |
| **Contact Details:** |  |
| **Medicare No.** |  |
| **Private health insurance details, if applicable:** |  |

|  |  |
| --- | --- |
| **Details of patient’s usual GP:** | **Details of patient’s carer (if applicable):** |

|  |
| --- |
| **If the patient has a previous or existing care plan, when was it prepared and what were the outcomes:** |

|  |
| --- |
| **Other notes or comments relevant to the patient’s care planning:** |

|  |
| --- |
| **Medications:** |

|  |
| --- |
| **Allergies:** |

**Patient’s Name:**

**I have explained the steps and costs involved, and the patient has agreed to proceed with the service**

(GP’s signature and date)

|  |  |  |  |
| --- | --- | --- | --- |
| **PREPARATION OF A GP MANAGEMENT PLAN (ITEM 721)** | | | |
| **Patient’s health problems / health needs / relevant conditions** | **Management goals with which the patient agrees** | **Treatment and services required, including actions to be taken by the patient** | **Arrangements for providing treatment/services (when, who, contact details)** |
| Activity pacing  Graded exercise therapy |  |  |  |
| **Copy of GPMP offered to patient?** YES /NO    **Copy/relevant parts of the GPMP supplied to other providers?** YES / NO / NOT REQUIRED  **GPMP added to the patient’s records?** YES / NO  **Review date for this plan:** dd/ mm / yy | | | |

**Patient’s Name:**

|  |  |  |
| --- | --- | --- |
| **I have explained the steps and costs involved, and the patient has agreed to proceed with the service**  (GP’s signature and date) | | |
|  | | |
| **COORDINATION OF TEAM CARE ARRANGEMENTS (ITEM 723)** | | |
| **Treatment and service goals for the patient / changes to be achieved** | **Treatment and services that collaborating providers will provide to the patient** | **Actions to be taken by the patient** |
|  |  |  |
| **Copy of TCAs offered to patient?** YES / NO  **Copy / relevant parts of the TCAs supplied to other collaborating providers?** YES / NO / NOT REQUIRED  **TCAs added to the patient’s records?** YES / NO  **Referral forms for Medicare allied health services completed?** YES / NO  The referral form issued by the Department can be found at www.health.gov.au/mbsprimarycareitems or a form can be used that contains all of the components of the Department's form.  **Review date for these TCAs:**  dd/ mm / yy | | |