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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 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 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 serviceEligible 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)**

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| --- | --- |
| **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):** |

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

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

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| **Medications:** |

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| **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)

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| **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 pacingGraded 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:**

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| **I have explained the steps and costs involved, and the patient has agreed to proceed with the service**  (GP’s signature and date) |
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| **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 / NOThe 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   |