GREAT SOUTHERN
Integrated Chronic Disease Care (ICDC) Referral

Client details	
Name:	Home / Work phone:
Address:	Mobile phone:
Date of birth: Age:	Medicare #: Ref #:
Client identifies as: ☐ Aboriginal ☐ Torres Strait Islander ☐ CALD	Health Care Card #:
Gender: ☐ Male ☐ Female ☐ Indeterminate/ Unspecified	NDIS: ☐ No ☐ Yes Plan No.:
Speaks English? ☐ Very Well ☐ Well ☐ Not Well ☐ Not at all	Preferred Language:
Client has carer: ☐ No ☐ Yes	Carer phone:
Carer Name:	NOK Name / Phone #:
General Practitioner or Nurse Practitioner details	
Name:	Phone:
Practice name:	Email:
Practice address:	Fax:

Eligibility:

- Client must be 18 years or older.
- Client must require Care Coordination support.
- Client must have current GP Management Plan.
- Must reside in funded service area.

Chronic disease/s (required – please tick)
*The patient must be **diagnosed** with at least **one** of these chronic conditions:*

☐ **Diabetes**	☐ **Respiratory**	☐ **Cardiovascular**	☐ **Morbid Obesity**
Type: _____	Condition: _____	Condition: _____	BMI: _____
Date diagnosed: _____	Date diagnosed: _____	Date diagnosed: _____	Date diagnosed: _____

GP Management Plan (required – include medical history/health summary and medication)

☐ Current GP Management Plan attached

☐ Other relevant health summary and/or pathology attached

GPMP Expiry Date:

Allied health services recommended or to be considered

☐ Care Coordination
☐ COPD / Asthma Educator
☐ Diabetes Educator
☐ Dietitian
☐ Exercise Physiologist
☐ Podiatry
☐ Respiratory Physiotherapy

(***Please note:*** *Not all allied health services are available in all locations, depending on availability and eligibility)*

Supporting reason for referral, if required (e.g. needs more intensive support, change of medication, foot ulcer, recent cardiac event)

This program aims to improve the health of vulnerable, disadvantaged or otherwise eligible individuals in the Great Southern region who are diagnosed with cardiovascular, diabetes, morbid obesity or respiratory conditions. The client gives consent to be contacted by the ICDC Care Coordinator to plan future multidisciplinary care, including telehealth services where appropriate.

Client signature: _____ Date: _____

Referrer signature: _____ Date: _____

Send completed form to Amity Health – fax: 9842 2798 or email query@amityhealth.com.au

Amity Health acknowledges WA Primary Health Alliance (WAPHA) for providing funding in its role as the operator of the Country WA PHN
http://www.wapha.org.au