Care Coordination and Supplementary Services (CCSS)

GP Referral Form

Client Name		**DOB**	
Address			
Contact Number		**Medicare Number**	
Pensioner/Health Care Card Number		**Gender**	

Practice Name		**Phone Number**	
Referring GP		**Provider Number**	

Does this client have a carer? ☐ **Yes** ☐ **No**		**Relationship**	
Name		**Contact Number**	
Address			

CLIENT ELIGIBILITY **Aboriginal and/or Torres Strait Islander**

☐ Aboriginal ☐ Torres Strait Islander ☐ Aboriginal and Torres Strait Islander

CLIENT ELIGIBILITY **Patient has at least one of the following chronic conditions**

☐ Diabetes ☐ Chronic Respiratory Disease ☐ Chronic Kidney Disease

☐ Cancer ☐ Cardiovascular Disease

CLIENT ELIGIBILITY **GPMP (721) or TCA (723) (please attach copy to referral)**

☐ GPMP ☐ TCA

What barriers are present? Please tick applicable box/es.

☐ Inability to self-manage	☐ Functional disability	☐ Not attending appointments due to cost
☐ Transport	Other	

Service required? Please tick applicable box/es.

☐ Care Coordination	☐ Specialist care	☐ Allied health	☐ Transport

Equipment Required. Please tick applicable box/es.

☐ Dose Administration Aids

☐ Blood Glucose Monitoring Equipment

☐ Medical Footwear prescribed and fitted by a Podiatrist

☐ Assistive Breathing Equipment (asthma spacers, nebulisers, masks, CPAP machines and accessories)	
What type of assistive breathing equipment?	
☐ Other (subject to NCPHN CCSS Governance Committee review)	

Specialist/Allied Health Referral Details. Detail below and provide copy of referral. (Leave blank, if no referral)			
1st Service Provider			
Phone Number			
Has appointment been made?	☐ Yes ☐ No	**Appointment Date**	

Specialist/Allied Health Referral Details. Detail below and provide copy of referral. (Leave blank, if no referral)			
2nd Service Provider			
Phone Number			
Has appointment been made?	☐ Yes ☐ No	**Appointment Date**	

Consent	The patient has given his/her consent to present this referral to the CCSS program and agrees with the following statement.		
"I have been informed of the CCSS program and how it operates. I give permission for my information to be used in discussion with another health provider in relation to my GPMP/TCA and health care. I also give permission for CCSS program staff to collect de-identified information as required for reporting to NCPHN's funding body."			
Patient Signature		**Date**	
GP Signature		**Date**	

CCSS Referral Checklist. Please ensure that you have provided all necessary details.

- ☐ Patient information has been provided.
- ☐ Patient has been identified as Aboriginal and/or Torres Strait Islander.
- ☐ Chronic disease/s has been detailed.
- ☐ Copy of GPMP and/or TCA is attached.
- ☐ Type of service and equipment required has been detailed.
- ☐ Referral/s to Specialist and/or Allied Health provider, detailed and referral/s attached (if required).
- ☐ Patient and GP signature provided.

PLEASE FAX THIS REFERRAL TO THE RELEVANT NCPHN OFFICE

Tweed Heads 07 5589 0599 Lismore 02 6622 3185 Coffs Harbour 02 6659 1899

Kempsey 02 6562 1044 Port Macquarie 02 6583 8600