Sonder
Better Care Better Health

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# **Closing the Gap** Integrated Team Care
## Referral Form

The ITC Program is a short-term program to: support Aboriginal and Torres Strait Islander people with complex chronic care needs to improve self-management of their condition; support access to clinically necessary medical equipment and/or services that would otherwise be inaccessible in a clinically appropriate timeframe; and/or to provide care coordination.

**PLEASE NOTE: Referrals will be prioritised according to the level of care coordination required.**

| **Patient Details** | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| **First Name:** | | **Last Name:** | | | | | | | |
| **Address:** | | | | | | | | | |
| **Postcode:** | | **Phone:** | | **Mobile:** | | | | | |
| **Patient identifies as:** | ☐ **Aboriginal** ☐ **Torres Strait Islander** | | | | **DOB:** | / / | | | |
| **Referral Date:** | / / | **Medicare No.:** | | **Exp.:** | | **CRN No.:** | | **Exp.:** | |

| **Referrer Details ( Please complete ALL details below marked with *)** | | | | | |
|---|---|---|---|---|---|
| **Title:** | **Dr☐Mr☐Mrs☐Ms☐** | **Name: *** | | **Position: *** | |
| **Organisation/Practice: *** | | | | | |
| **Address: *** | | | | | |
| **Suburb: *** | | | **Post Code:** | | |
| **Email: *** | | **Phone: *** | | **Fax: *** | |

**My patient fulfils ALL the criteria below:**

- ☐ Is Aboriginal or Torres Strait Islander or Aboriginal and Torres Strait Islander
- ☐ Has chronic and complex health needs and may require multidisciplinary care
- ☐ Has a care plan/GP Management Plan. Attach patient Care Plan with Referral
- ☐ Has given verbal or written consent to be contacted by the ITC team to discuss participation in the ITC Program

| **Chronic Disease Details (Tick ALL applicable to patient)** | |
|---|---|
| ☐ **Diabetes** | ☐ **Eye health condition associated with diabetes** |
| ☐ **Cardiovascular disease** | ☐ **Chronic kidney disease** |
| ☐ **Cancer** | ☐ **Chronic respiratory disease** |
| ☐ **Other – please specify:** | |

| Reason/s for ITC Referral | |
|---|---|
| ☐ Requires care coordination support | ☐ Current ITC client moving to new ITC Provider region |
| ☐ Requires care coordination and Supplementary Services support | ☐ Patient has exhausted Medicare CDM Allied Health visits |
| Provide brief details as per care plan: | |
| E.g. Request Care Coordination and Medicare Gap payment support for 2 x Podiatrist services. Upcoming appointment *(insert appointment date)* | |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| **GP Name:** * | | | | | | | |
| **Practice Name:** * | | | | | | | |
| **Address:** * | | | | | | | |
| **Suburb:** * | | **PC:** | | **Phone:** * | | **Fax:** * | |

**Relevant medical history (please give details)**

NOTE: A current GPMP **MUST** accompany this referral to be triaged accordingly.

**Consent to use of personal information**

For referral to Integrated Team Care Program, clients should be aware of the following:-

Sonder will be required to store the information supplied on this form in a way that protects your privacy and will not be permitted to disclose information about you to anyone else.

Some data which will not identify you will be given to the Commonwealth Department of Health so that the program can be monitored and evaluated.

By signing this information and consent to disclosure section, you are saying that you understand the above procedure and that you are giving your consent for Sonder Care to store client information relating to the assistances you will be receiving.

You are also giving permission to be contacted by Aboriginal and Torres Strait Islander Outreach Worker from Sonder Care, in order to discuss how they can assist you to better access primary healthcare and other services.

…… ……/……/……..
Signature Date

Please fax to Closing the Gap on (O8) 8252 9433
or email ctgreferrals@sonder.net.au