Country SA PHN

Care Coordination and Supplementary Services (CCSS) Referral

REFERRAL DATE: _____/_____/_____

GP DETAILS	
GP Name:	Phone:
Practice Name/Address:	Fax:

CLIENT DETAILS		
Name:	Date of Birth:	Phone:
Address:		Gender: □ Male □ Female

CLIENT ELIGIBILITY		
Does the patient identify as: □ Aboriginal □ Torres Strait Islander □ Both Aboriginal and Torres Strait Islander	Does the client have a care plan? *(Please send with referral)* □ Yes □ No	Has the client had an Aboriginal Health Assessment (item 715) □ Yes □ No
	Has the client been identified as having a Chronic Disease? □ Yes □ No	
	Has the client given CONSENT for this referral? □ Yes □ No	
	Has the client been registered for the Practice Incentive Program (PIP) Indigenous Health Incentive (IHI)? □ Yes □ No	
IMPORTANT: *If the answer to any of the above is* ***NO****, please contact the Care Coordinator on 86435610*		

Please indicate by ticking (more than one if applicable) which of the following Chronic Disease/s the client has:		
□ Cancer	□ Diabetes	□ Cardiovascular Disease
□ Chronic Kidney Disease	□ Chronic Respiratory Disease	

Please indicate the reason for referral:

Please indicate the Closing the Gap Team (s) relevant for this referral:		
□ Nuriootpa Head Office Beckwith Park 30 Tanunda Road NURIOOTPA SA 5355 P 08 8565 8500 F 08 8312 2506	□ Kadina Office Yorke Peninsula/Mid North/Barossa 73 Taylor Street KADINA SA 5554 P 08 8821 6700 F 08 8821 4068	□ Port Augusta Office Port Augusta/Country North/APY Lands 71 Hospital Road PORT AUGUSTA SA 5700 P 08 8643 5600 F 08 8642 3766
□ Ceduna Office	□ Remote Regions 30 Tanunda Road NURIOOTPA SA 5355 P 08 8565 8500 F 08 8312 2506	□ Other Please indicate which one.

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Please mail or fax a copy of the Care Plan, Consent Form and this Referral to: Care Coordinator, Closing the Gap Team, Country SA PHN, Nuriootpa Head Office on 08 8312 2506
Please mark as (Private and Confidential).

Signature: _____ (Referring GP) Date: _____/_____/_____

Patient Information and Consent
My GP or care Coordinator has discussed the CCSS Program with me. I understand what I have been told, any questions I had about the program have been satisfactorily answered and I now want to participate. • I understand that my participation is voluntary and that I have the right to withdraw from the Program at any time. • I understand that a range of health and community service providers may collect, use and disclose my relevant personal information as part of my care. • I understand that the personal information collected by these organisations will be maintained consistent with National Privacy Principles. It will remain confidential except when it is legal requirement to disclose information; or where failure to disclose information would place me or another person at risk; or when my written consent has been obtained to release the information to a third party. • I understand that statistical information (that will not identify me) will be collected and used to see how well the Program is working and help me improve services for Aboriginal and Torres Strait Islander people. • I agree the CSAPHN may access data relating to my hospital utilisation if I attended/have attended any hospital and the use of this information for research and evaluation purposes only. I am aware that this information will not refer to my private medical problems and will only relate to information relating to hospital visits and stays. • Should I wish to access my information, a written application can be made to: Chief Executive Officer, CSAPHN, 30 Tanunda Road, NURIOOPTA SA 5355
Patient or parent/guardian's full name:
Verbal consent has been given:
Date: