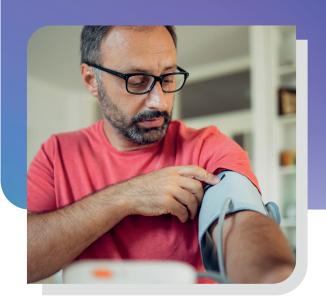
How do I access the service?

You will need to:

- Have at least one long-term medical condition
- live within the North Brisbane and Moreton Bay region
- have a GP who works within the North Brisbane and Moreton Bay region (preferable only).





Want to know more or be referred?

Speak to hospital staff or your General Practitioner (GP or local doctor) about Team Care Coordination or phone us directly on **1800 250 502** for more information.

www.brisbanenorthphn.org.au



Team Care Coordination is managed by Brisbane North PHN and is supported financially by Metro North Hospital and Health Service.



Living with a long-term health condition can have an enormous impact on you and your family. The Team Care Coordination program can support you to cope with this challenge.

This service provides information, support and coordination of appropriate health and community services to help you to maintain and improve your quality of life, and remain living well in your own home.

To ensure the appropriate and timely delivery of healthcare services that meet your individual needs, we liaise with service providers and healthcare professionals on your behalf.

This is a free service delivered by a clinical team who have a wealth of knowledge about local public, community and private healthcare services.

Our team can visit you at your home or provide support over the phone. The choice is yours.

How can Team Care Coordination help you?

Our team can help you with any of the following, depending on your specific needs:

- understanding your health conditions and their management
- finding out what home and community services are available to support you
- understanding how to access My Aged Care, services for Under 65s and NDIS
- support to access some immediate short-term services
- support and information to help you to navigate the healthcare system
- help with Advance Care Planning, to ensure your healthcare preferences can be respected in the future when you may be unable to voice your own decisions
- referral to appropriate home, medical and community services

- coordination and monitoring of referred services
- information about how to access respite and residential ages care

