Team Care Coordination

Community Referral Form

Referral Form for Community Providers Only

Please fax referral to Team Care Coordination Fax 07 3630 7808 or via secure email Mimecast.

Team Care Coordination program is a free service for people living with long-term chronic health conditions. The program aims to improve people's self-management and quality of life that supports them to remain living well at home. Our Clinical Nurses liaise with the patients GP, hospital and other community services to assess the person's healthcare needs and coordinate services.

Referral information

Referral date:	

Eligibility

Client is eligible for Team Care Coordination if **all** answers in this section are YES. Please tick or highlight to indicate your answer below.

Does the client live in the North Brisbane and Moreton Bay region?	Yes ☐	No ☐
Is the client aged 18 years and over?	Yes ☐	No ☐
Does the client have one or more long-term chronic health conditions?	Yes ☐	No ☐
If the primary referral reason is mental health, is the client currently connected with a psychologist, psychiatrist, or other mental health professional?	Yes ☐	No ☐
Does the client require ongoing support and coordination of health and community services?	Yes ☐	No ☐

Ineligible for Team Care Coordination

Client is not eligible for Team Care Coordination if **any** answers in this section are YES. Please tick or highlight to indicate your answer below.

Is the client living in residential aged care?	Yes ☐	No ☐

Does the client require equipment only?	Yes ☐	No ☐
Is the client receiving end of life palliative care services?	Yes ☐	No ☐
Does the client require support with a NDIS application or OT functional assessment?	Yes ☐	No ☐

Client details

Given names		Surname	
Address			
Phone		Mobile	
Date of birth		Sex	Male ☐ Female ☐ Other ☐
Medicare Card number		Medicare ID/Expiry	
Contact Person		Phone	
Living Circumstance	Lives alone ☐ Lives with Family ☐ Lives with Other ☐ RACH (Residential Aged Care Home) ☐ Unknown ☐	Marital Status	Never Married ☐ Widowed ☐ Divorced ☐ Separated ☐ Married (registered and de-facto) ☐ Not stated ☐
Country of Birth		Language at Home	
Interpreter required?	Yes ☐ No ☐		
Aboriginal &/or Torres Strait Islander Status	Neither Aboriginal or Torres Strait Islander ☐ Aboriginal ☐ Torres Strait Islander ☐ Both Aboriginal & Torres Strait Islander ☐ Not stated ☐		
GP name			

GP practice name			
GP address		GP phone	
Client medical history			
Other referrals made			
Referral to My Aged Care	Yes ☐ No ☐ If yes, date client referred?		
Services already in place			
Risk to staff safety (Client/Environment)	Yes ☐ No ☐		
Referrer name		Designation	
Department		Company Name	
Phone		Email & Fax	
Referrer consent for feedback/updates for this referral from TCC via secure email or fax	Yes ☐ No ☐		
Specific help required and client's goals/outcomes			

Client Consented to referral?	Yes ☐	No ☐

Please attach any medical or discharge reports with referral, by sending client information to Team Care Coordination it is acknowledged the patient has verbally agreed to this referral.

Brisbane North PHN prefers to use secure messaging and secure faxing to safeguard personal information against unauthorised access, use, modification or disclosure.