|  |
| --- |
| **Please fax referral to Central Referral Unit:**  Fax 07 3360 4822 |

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**

Patient is eligible for Team Care Coordination if all answers in this section are YES. Please circle or highlight to indicate answer.

|  |  |  |
| --- | --- | --- |
| Does the patient lives in North Brisbane and Moreton Bay region | Yes | No |
| Does the patient have one or more long-term chronic health conditions  | Yes | No |
| Does the patient require ongoing support and coordination of health and community services post admission/ post-acute care services  | Yes | No |

**Ineligible for Team Care Coordination**

Patient is not eligible for Team Care Coordination if **any** answers in this section are YES. Please circle or highlight to indicate answer.

|  |  |  |
| --- | --- | --- |
| Is the person living in residential aged care? | Yes | No |
| Is the person receiving a comprehensive package though NDIS? | Yes | No |
| Is the person receiving end of life palliative care services?  | Yes | No |

**Patient details**

|  |  |  |  |
| --- | --- | --- | --- |
| First name |       | Surname |       |
| Address |       |
| Phone |       | Mobile |       |
| Date of birth |       | Hospital UR |       |
| Contact Person |       | Phone |       |
| GP name |       |
| GP practice name |       |
| GP address |       | GP phone |       |
| Medical history |       |
| Admission details |       |
| Admission date |       | Discharge date |       |
| Other referrals made |       |
| Services already in place |       |
| Referrer name |       | Designation |       |
| Department |       | Hospital name |       |
| Phone |       | Fax |       |
| Specific help required for this patient |       |

|  |  |  |
| --- | --- | --- |
| Patient Consented to referral | Yes | No |

Please attach any medical or discharge reports with referral, by sending patient 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.**