cohealth

REFERRAL FORM

Care Coordination and Supplementary Services (CCSS) Program

For Aboriginal and Torres Strait Islander people

Referral Date:_____

Care Coordinators	Referral
Gill Lowe (Cities of Yarra and Melbourne) or Penny Angus (Moonee Valley, Moreland, Brimbank & Maribyrnong)	Fax: 03 9348 0750
Ph: 9411 3555/9334 6699	Email: ccss@nwmphn.org.au

Program Eligibility	
The patient has a care plan: Y N	Care Plan Attached ☐
The patient has the following chronic disease(s):	
Referrer Details	
GP Name:	Practice Name:
Phone Number: GP Provider Number:	Email:
Practice Address:	
Practice nurse contact details:	

Patient Details		
Surname:		First Name:
Date of Birth	Gender: F M	
Contact Numbers:		
Residential Address:		
Alternate contact:	Name:	Ph:

Reason for care coordination
☐ Risk of avoidable hospital admission
☐ Risk of inappropriate use of services, such at emergency department presentations
☐ Patient needs help to overcome barriers to access services
☐ Patient requires more intensive care coordination than is currently able to be provided
☐ Patient is unable to manage the complexity of their health needs

Reason for care coordination and supplementary services **(the provision of medical specialist, allied health services or transport services in accordance with their care plan)**
☐ To address risk factors, such as a waiting period for a service longer than is clinically appropriate
☐ To reduce the likelihood of a hospital admission
☐ To reduce the patient's length of stay in hospital
☐ To ensure access to a clinical service that would not be accessible because of the cost of a local transport service
☐ To access medical aids (as specified in CCSS guidelines)

Patient information and consent

• My GP has explained the purpose of this referral for care coordination • I give permission for my medical information to be shared with the care coordinator and other service providers as clinically appropriate • I understand that all information is held in strict confidence in accordance with our privacy policies
Patient name and signature:
Date:

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