

**Referral Request Form - Chronic Care Program**

URN: \_\_\_\_\_

Family name: \_\_\_\_\_

Given names: \_\_\_\_\_

DOB: \_\_\_\_\_ Sex: \_\_\_\_\_

**Please complete and fax to the Chronic Care Program on 6244 2606 or email [chroniccareprogram@act.gov.au](mailto:chroniccareprogram@act.gov.au)**

|  |                |
|--|----------------|
| Referrer's name                              | Specialist     |
| Referrer's designation and location          | GP Name/suburb |
| Referrer's contact details<br>Phone:<br>Fax: | GP phone       |

Consent for referral obtained from patient  Yes  No  EPOA  
**Note: Further information about the Care Coordination Service as well as a consumer handout can be found on the intranet under the 'Policies/Clinical Guidance' tab.**

Confirmed diagnosis of Heart Failure:  Yes  No  
 Confirmed diagnosis of COPD:  Yes  No  
 Diagnosis of PD, MSA, CBD, or PSP:  Yes  No

Reason for Referral

Medical History / Co-morbidities *(Please attach a relevant discharge summary if available)*

Other Information *(include patient's phone contacts and EPOA if relevant)*

\_\_\_\_\_  
Signature Date

**Eligibility criteria**

- Adult (> 18 years old) ACT resident
- Under the care of a relevant specialist (cardiologist, neurologist/geriatrician or respiratory specialist) with a documented medical management plan for their Heart Failure, Chronic Obstructive Pulmonary Disease, Parkinson's Disease or other conditions by arrangement with the Chronic Care Program Manager
- Has a need for psychosocial or clinical assistance to overcome barriers that may be affecting the patient from self-managing their chronic condition
- More than 2 presentations per annum to hospital related to their chronic condition

*For clients who are acutely psychiatrically unwell, referral to a mental health service is the most appropriate response.*

**OFFICE USE ONLY – DO NOT COMPLETE**

Date received:  
 Eligible  Non eligible Reason if not eligible: \_\_\_\_\_

\_\_\_\_\_  
Signature Print name Designation Date



DO NOT WRITE IN THIS BINDING MARGIN

REFERRAL REQUEST FORM - CHRONIC CARE PROGRAM

## CLINICIAN INFORMATION

### **What is the Chronic Care Program?**

The Chronic Care Program (CCP) provides clinical care coordination services for people living in the community with chronic heart failure (CHF), chronic obstructive pulmonary disease (COPD) and Parkinson's Disease (PD), who have had several hospital admissions or ED presentations over the past two years.

### **How can we help?**

A comprehensive patient-centred assessment is performed. Goal setting interventions are then developed with the patient and the health professionals involved in care. The aim is to assist in maintaining a coordinated approach to managing the patient's condition. The care is client-centred, focussing on the development and/or support of self-management skills. Our aim is to assist the client to remain well in the community, navigate and engage with our health system and prevent unnecessary hospital presentations and admissions.

### **Chronic Care Program service includes:**

- Care coordination from a Clinical Care Coordinator who can:
- Arrange support services for the patient in the community to assist health management.
- Provide patient education and strategies to help self-manage their condition.
- Provide ongoing patient contact via home visits and phone consultation.
- Liaise and advocate with patient's GP, Specialist and other health care professionals/service providers regarding appointments and care; and
- Discuss Advanced Care Planning in line with patient's wishes.

**Our program is linked with nursing services from Clinical Nurse Consultants (CNCs) in the specialty fields listed above.**

For further information, call the Chronic Care Program on 02 6244 2273