

Integrated Team Care Client Referral and Consent Form

The Integrated Team Care Program, which incorporates the Care Coordination and Supplementary Services, is for Aboriginal and/or Torres Strait Islander People who have a diagnosed Chronic Disease that has been or likely to be there for six months or more.

HealthWISE New England North West are working to assist you/your patient to manage their Chronic Disease/s.

Each case will be assessed on the information provided and the level of support will be determined on a case by case basis and subject to Hunter New England Central Coast Primary Health Network (HNECC PHN) guidelines, policies and procedures of HealthWISE staff capacity and the level of funding available for supplementary services. An updated General Practitioner Management Plan (GPMP) will be required as part of the eligibility requirements for Care Co-ordination.

1. This form, once signed, will register you or your patient to become a client of the ITC Program run by both HealthWISE New England North West.
2. Registration will allow the ITC Team to access and share necessary health information with health providers and other relevant service providers who are identified to support the overall health outcomes.
3. All information shared between the client and HealthWISE will be treated as strictly confidential at all times.
4. At any stage your patient can request to be removed from this program by notifying the ITC Team.
5. All data collected that will be used for reporting purposes will be de-identified.
6. You or your patient will notify HealthWISE if they are receiving any other assistance that supports your patient to manage their Chronic Disease. E.g. IPTASS
7. You or your patient will provide the ITC Team with a minimum of two weeks' notice if travel and/or accommodation is required.
8. All correspondence held by HealthWISE and partners that relate to purchasing of travel / accommodation services or medical aids will remain the property of HealthWISE and partners.
9. HealthWISE have a Zero Tolerance policy for abusive behavior. Any breaches of behavior towards staff or service providers for this program, may result in you or your patient being released from this program.

Consent



I, (or my child/ward)

Full name: _____

DOB: ____/____/____ Male/Female (Please Circle)

Address:

(Not PO Box) _____

Contact Phone number: _____

Regular GP Name: _____

Hereby agree to my (or my child/ward's) records being kept in a secure medical software program of HealthWISE New England North West Health. I acknowledge that the purpose of the holding this information is to assist in the management of my chronic disease/s and used for de-identified reporting to funding providers.

I understand that my health condition/s may be accessible to Health Service providers involved in my (or my child/ward's) care.

This consent is subject to:

1. The information retained on the medical software being kept strictly confidential;
2. Any information required for research being used on de-identified data reports;
3. My right to withdraw consent at any time by informing the Integrated Care Team.
4. My Medical History and diagnosis being discussed with my GP and other health professionals involved in my care as determined by my General Practitioner Management Plan. *(Please note, a GPMP will need to be completed in order to access the Care Co-ordination program, this can be obtained through your GP.)*

Patient Signature: _____ Date: ____/____/____

Parent/Guardian Name: _____

Parent/Guardian Signature: _____ Date: ____/____/____

Please forward Signed and Completed form with a current GPMP to your nearest HealthWISE Care Coordinator or please call for further information.

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|----------|--|-----------------|-----------------|
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