South Eastern Sydney Local Health District

Facility: South East Aboriginal Health Care (SEAHC)

REFERRAL FOR CARE COORDINATION

FAMILY NAME	MRN
GIVEN NAME	☐ MALE ☐ FEMALE
D.O.B. _____ / _____ / _____	M.O.
ADDRESS	
LOCATION / WARD	

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

SES010440

REFERRAL FORM - SESLHD INTEGRATED TEAM CARE (SEAHC)

South Eastern Aboriginal Health Care (SEAHC) is a CESPHN funded program that supports Aboriginal and/or Torres Strait Islander people living with a chronic health condition in the SESLHD region - the lands of the Dharawal, Gadigal, Wangal, Gweagal and Bidjigal people. Aboriginality as defined by AIATSIS is being of Aboriginal or Torres Strait Islander descent, identifying as an Aboriginal or Torres Strait Islander person and being accepted as such by the community in which you live, or formerly lived.

PROGRAM ELIGIBLITY

Is the person of Aboriginal and Torres Strait Islander origin?

- ☐ No - please refer to relevant chronic disease program
- ☐ Yes, Aboriginal
- ☐ Yes, Torres Strait Islander
- ☐ Yes, both Aboriginal and Torres Strait Islander:

☐ Has given verbal consent to be referred to this program

Chronic health condition/s

- ☐ Cancer
- ☐ Chronic Renal Disease
- ☐ Diabetes
- ☐ Cardiovascular Disease
- ☐ Chronic Respiratory Disease
- ☐ Other:

Attached supporting documents:

- ☐ GP Management Plan (GPMP)
- ☐ Team Care Arrangements (TCA)
- ☐ 715 health assessment
- ☐ Other supporting documents

CLIENT DETAILS

FIRST NAME:	SURNAME:
DOB:	MRN (if inpatient):
ADDRESS:	HOME NUMBER: MOBILE NUMBER:
MEDICARE NUMBER __ __ __ __ __ __ __ __ __ __ __ Exp / / Position on card: __	CONCESSION CARD CRN __ __ __ - __ __ __ - __ __ __ __ Exp / /
CARER NAME (if applicable)	CARER CONTACT NUMBER:

SERVICES CURRENTLY RECEIVING

REGISTERED WITH NDIS?	☐ YES NDIS Reference Number: __ __ __ __ __ __ __ __ __ __ __ ☐ NO ☐ Unsure
REGISTERED FOR ACAT/ My Aged Care?	☐ YES AGED CARE ID: AC __ __ __ __ __ __ __ __ ☐ NO ☐ Unsure
KNOWN SUPPORT SERVICES	

REFERRAL FOR CARE COORDINATION

SES010.440

Holes Punched as per AS2828.1: 2019

BINDING MARGIN - NO WRITING

S0996A 180522

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WHAT DOES THE CLIENT WANT SUPPORT WITH? (Referral reason)

SEAHC SERVICES REQUESTING

- ☐ Aboriginal Health Outreach Worker cultural support/ advocacy
- ☐ Care Coordination / help to self-manage health condition
- ☐ Supplementary services request for:

Note supplementary services funding require a GPMP or supporting documentation to confirm the clinical need.

- ☐ Allied Health
- ☐ Specialist
- ☐ Medical Aids
- ☐ Medical Transport

GP DETAILS

GP NAME		PRACTICE NAME	
PHONE		FAX or EMAIL	

REFERRED BY

DATE		NAME	
PHONE		ORGANISATION	
EMAIL			

SEAHC REFERRAL CONTACT DETAILS

EMAIL	SESLHD-SEAHC@HEALTH.NSW.GOV.AU		
SECURE FAX	02 9540 8165	PHONE	02 9540 8181

Office only:

eMR updated		
Referral Acknowledged	Date:	Method:

NO WRITING