

GPMP & TCA (Item 721 & 723)

PATIENT DETAILS	DOCTOR PREPARING GPMP & TCA
Mr / Ms _____ Address: _____ _____ P/C: _____ DOB: _____ Medicare No.: _____	Dr _____ Provider No: _____ Address: _____ _____ Phone: _____ Fax: _____
MEDICAL HISTORY	CURRENT MEDICATIONS
<input type="checkbox"/> Ischaemic Heart Disease / CABG <input type="checkbox"/> Type 2 Diabetes <input type="checkbox"/> Hypercholesterolaemia / Dyslipidaemia <input type="checkbox"/> Hypertension <input type="checkbox"/> Osteoarthritis <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Depression Other: _____ _____ _____ _____ _____ _____	Medication List Attached: <input type="checkbox"/> Yes <input type="checkbox"/> No _____ _____ _____ _____ _____ _____ _____ _____

NEED	GOAL	ACTIONS	PROVIDERS	REVIEW DATE
<input type="checkbox"/> Maintain or improve blood sugars	Aim for HBA1c < _____% Maintain blood sugars near normal range Normal Range = 3 - 8 mmol/l	Meal Plan; Regular Meals; Low fat & Low GI; Reduce Alcohol; Regular Home Monitoring; Exercise programme prescribed by EP	<input type="checkbox"/> GP <input type="checkbox"/> Exercise Physiologist <input type="checkbox"/> Dietician <input type="checkbox"/> Diabetes Educator	3-6 months
<input type="checkbox"/> Weight Management	Aim for BMI < _____	Increase Physical Activity Appropriate Diet	<input type="checkbox"/> GP <input type="checkbox"/> Exercise Physiologist <input type="checkbox"/> Dietician	3-6 months
<input type="checkbox"/> Control Cholesterol	Aim for: Total Chol < 5 LDL Chol < 3 HDL Chol > 1 Triglycerides < 2	Review physical activity levels & eating habits Review Medications Regular blood tests	<input type="checkbox"/> GP <input type="checkbox"/> Exercise Physiologist <input type="checkbox"/> Dietician	If normal every 1-2 yrs; If abnormal every 3-6 mths
<input type="checkbox"/> Blood Pressure	Aim for BP < _____	Check every visit Medication review; Regular aerobic exercise	<input type="checkbox"/> GP <input type="checkbox"/> Exercise Physiologist	Every visit

<input type="checkbox"/> Joint Care	Improve range of motion / function of joints.	Structured physical activity program and range of motion exercises. Joint stability muscle strengthening.	<input type="checkbox"/> GP <input type="checkbox"/> Exercise Physiologist	3-6 months
<input type="checkbox"/> Improve Bone Health	Increase bone density and prevent fractures.	Weight-bearing activity; Routine activity; Adequate sun exposure (Vit D)	<input type="checkbox"/> GP <input type="checkbox"/> Exercise Physiologist	6-12 months
<input type="checkbox"/> Pain management	Able to perform daily activities unrestricted by pain	Graded exercise therapy & pain management techniques Analgesia (if necessary)	<input type="checkbox"/> Exercise physiologist <input type="checkbox"/> GP	
<input type="checkbox"/> Depression &/or Anxiety	Improved coping mechanisms for anxiety &/or depression; reduced severity of symptoms	Graded exercise therapy (GET) Cognitive behavioural therapy (CBT) Medication (if necessary)	<input type="checkbox"/> Exercise Physiologist <input type="checkbox"/> Psychologist <input type="checkbox"/> GP	

Comments: _____

HEALTH PROVIDERS / SERVICES

Care Provider	Category of Care	Phone	Fax
Dr	GP		
Lifestyle Clinic	Exercise Physiologist	9385 3352	9385 3195

PATIENT'S AGREEMENT

I have agreed / my carer has agreed to this team care arrangement and I give my consent that my GP may provide a copy of this TCA to other providers involved in my care.

Signed by Patient / Carer / or Verbal: _____ Date: _____

Signed by GP _____ Date: _____



Enhanced Primary Care (EPC) Program Referral form for Allied Health Services under Medicare

To be completed by referring GP:

Please tick the relevant box below:

- Patient has a GP Management Plan and Team Care Arrangements in place (new CDM MBS items 721 AND 723) OR
 Patient has an EPC Multidisciplinary Care Plan in place (former MBS items 720, 722 or 730; or new CDM item 731)

Note: GPs are encouraged to attach a copy of the relevant part of the patient's care plan to this form.

Medicare rebates and Private Health Insurance benefits cannot both be claimed for these services.
 Patients should be advised that they must choose whether to access one or the other.

GP details

NOTE: Relevant MBS item(s) above must be BILLED by GP prior to patient receiving their first referred allied health service for Medicare rebate to be payable for that service.

Provider Number

Name

Address Postcode

Patient details

Medicare Number Patient's ref no.

First Name Surname

Address Postcode

Allied Health Professional (AHP) patient referred to: (Please specify name or type of AHP)

Name LIFESTYLE CLINIC (EXERCISE PHYSIOLOGIST)

Address 38 BOTANY STREET (Corner Botany and High Streets) RANDWICK NSW Postcode 2031

Referral details – Please use a separate copy of the referral form for each type of service

Eligible patients may access Medicare rebates for up to 5 allied health services (total) in a calendar year. Please indicate the number of services required by writing the number in the 'No. of services' column next to the relevant AHP.

No of services	AHP Type	Item Number	No of services	AHP Type	Item Number	No of services	AHP Type	Item Number
	Aboriginal Health Worker	10950		Dietitian	10954		Physiotherapist	10960
	Audiologist	10952	5	Exercise Physiologist	10953		Podiatrist	10962
	Chiropractor	10964		Mental Health Worker	10956		Psychologist	10968
	Chiropodist	10962		Occupational Therapist	10958		Speech Pathologist	10970
	Diabetes Educator	10951		Osteopath	10966			

Referring General Practitioner's signature

Date signed

AHP must provide a written report to patient's GP after each service – except where the AHP provides multiple services to a patient under the one referral. In this case, the AHP must provide a written report to the patient's GP after the first and last service, and more often if clinically necessary.

Allied health professionals should retain this referral form for record keeping and Medicare Australia audit purposes.

Allied health services funded by other Commonwealth or State/Territory programs are not eligible for Medicare rebates under this initiative.

This form may be downloaded from the Department of Health and Ageing website at www.health.gov.au/strengtheningmedicare or ordered by faxing (02) 6289 7120.

THIS FORM DOES NOT HAVE TO ACCOMPANY MEDICARE CLAIMS