GPMP & TCA (Item 721 & 723)

PATIENT DETAILS	DOCTOR PREPARING GPMP & TCA
Mr / Ms ______________________	Dr ______________________
Address: ______________________	Provider No: ______________________
______________________ P/C:________	Address: ______________________
DOB: ______________________	______________________
	Phone: ______________________
Medicare No.: __ __ __ __ __ __ __ __ __ __ __	Fax: ______________________

MEDICAL HISTORY	CURRENT MEDICATIONS
☐ Ischaemic Heart Disease / CABG	*Medication List Attached*: ☐ Yes ☐ No
☐ Type 2 Diabetes	______________________
☐ Hypercholesterolaemia ☐ Hypertension	______________________
☐ Osteoarthritis ☐ Osteoporosis	______________________
☐ Depression / Anxiety	______________________
☐ Cancer: ______________________ (type)	______________________
Other: ______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________
______________________	

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

☐ Joint Care	Improve range of motion / function of joints.	Structured physical activity program and range of motion exercises. Joint stability muscle strengthening.	☐ GP ☐ Exercise Physiologist	3-6 months
☐ Improve Bone Health	Increase bone density and prevent fractures.	Weight-bearing activity; Routine activity; Adequate sun exposure (Vit D)	☐ GP ☐ Exercise Physiologist	6-12 months
☐ Pain management	Able to perform daily activities unrestricted by pain	Graded exercise therapy & pain management techniques Analgesia (if necessary)	☐ Exercise physiologist ☐ GP	
☐ 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)	☐ Exercise Physiologist ☐ Psychologist ☐ GP	

Comments: ____

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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: _____________

Referral Form for Individual Allied Health Services under Medicare for patients with a chronic medical condition and complex care needs

Note: GPs can use this form issued by the Department of Health or one that contains all of the components of this form.

To be completed by referring GP:

Please tick:

☒ Patient has GP Management Plan (item 721) AND Team Care Arrangements (item 723) OR

☐ GP has contributed to or reviewed a multidisciplinary care plan prepared by the patient's aged care facility (item 731)

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

GP details

Provider Number ☐☐☐☐☐☐☐☐☐☐

Name

Address Postcode

Patient details

Medicare Number ☐☐☐☐☐☐☐☐☐☐ Patient's ref no. ☐

First Name Surname

Address Postcode

Allied Health Provider (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 a maximum of 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/Aboriginal and Torres Strait Islander Health Practitioner	10950	5	Exercise Physiologist	10953		Podiatrist	10962
	Audiologist	10952		Mental Health Worker	10956		Psychologist	10968
	Chiropractor	10964		Occupational Therapist	10958		Speech Pathologist	10970
	Diabetes Educator	10951		Osteopath	10966			
	Dietitian	10954		Physiotherapist	10960			

Referring General Practitioner's signature

Date signed

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 providers should retain this referral form for record keeping and Department of Human Services (Medicare) audit purposes.

This form may be downloaded from the Department of Health website at www.health.gov.au/mbsprimarycareitems

THE FORM DOES NOT HAVE TO ACCOMPANY MEDICARE CLAIMS