My Care Partners Referral Form

DATE OF REFERRAL	

URGENCY

☐ **Low** ☐ **Medium** ☐ **High** Reason:

PATIENT DETAILS

Family name:	**Given Names:**	
Sex:	**Date of Birth:**	**MRN:**
Address:		
Phone (H):	**Phone (M):**	**Phone (W):**
Email:		
Aboriginal and Torres Strait Islander Status: **RFT fields: Aboriginal / Torres Strait Islander / Both / Neither / Prefer not to say**		
Interpreter Required: ☐ Yes ☐ No (If yes, language spoken):		
Has the patient opted out of My Health Record? ☐ **YES** ☐ **NO**		
Medicare card no: **IRN:** **Expiry (month/year):** NOTE: Pt must have Medicare to be eligible for MCP		
DVA Card Number: Card Type: NOTE: If DVA Card Holder, refer to DVA unless Hospital Avoidance category of client.		
Pension/Health Care Card No:	**Private Health Insurer:**	
NDIS Participant: Yes / No	**NDIS participant number:**	
Marital Status:	**Occupation:**	
Current GP Management Plan in place: ☐**YES** ☐**NO** Ensure GPMP/TCA is saved to clinical software with naming convention	**Date last updated:**	
Current Team Care arrangement in place: ☐**YES** ☐**NO**	**Date last updated:**	

ELIGIBILITY

Tick the option that applies to the patient	YES	NO
1. Is the patient at risk of hospitalisation in the next 12 months?	☐	☐
2. Is the patient living with a complex or chronic illness with complex/unmet needs?	☐	☐
3. Does the patient require coordination of their care?	☐	☐
4. Is the patient committed to actively participating in the program for the duration of 12 months?	☐	☐
5. Is the patient available to engage for the entire 3-month intervention period?	☐	☐
6. Is the patient's primary chronic condition mental health related?	☐	☐
7. Does the patient currently live in an RACF (excluding independent living options)?	☐	☐
8. Is the patient currently pregnant?	☐	☐
9. Is the patient under 16 years old?		

If you answered yes to questions 6-9, this patient is NOT ELIGIBLE for My Care Partners

NEXT OF KIN/CARER

Name:	Relationship to patient:
Phone:	Email:
Address:	
Power of Attorney or Guardian appointed: ☐YES ☐NO If yes, please provide details:	
Contact: ☐ Client ☐ Carer/NOK	**Risk of carer burnout/stress: ☐ YES ☐ NO**

REFERRER DETAILS

Referring practice:	
Doctor's name:	
Phone:	**Fax:**
Address:	
Email:	

MEDICAL HISTORY

List all current chronic conditions:
Acute health deterioration/changes:
Other relevant medical history:

List all current medications:
Issues to be addressed during enrolment in this program:
Patient goals:

SOCIAL HISTORY

Please indicate which of the following social and environmental risk factors are present. Include details where relevant.

Cognitive impairment/decline ☐	**Lives alone without support/isolation** ☐
Evidence of financial strain ☐	**Unstable living environment/issues with housing** ☐
Concerns of elder abuse/domestic abuse ☐	**Nil other services engaged** ☐
Issues with access/transport difficulties ☐	**Squalor/self-neglect** ☐
Falls history/falls risk ☐	**Current mobility status** ☐
Other:	

Please record the patient's consent status in the clinical notes for their potential placement in My Care Partners. To aid the applicant's understanding of why each element is necessary within the program, refer to the GP quick reference guide and Patient Information Booklet.

	YES	NO
iRAD Db Motion consent form – *Please ensure you have completed and submitted the Db motion consent form. Note that the name of this document must not be changed.*	☐	☐
My Care Partners program consent	☐	☐
My Care Partners comprehensive assessment consent	☐	☐
My Care Partners Information sharing consent	☐	☐
My Care Partners evaluation consent	☐	☐

Back page:

Additional program information – if eligible the patient will be assessed by the SWSLHD Care Coordinator team and enrolled in one of the MCP care pathways:

The patient may be referred to other more appropriate services as required.

What is care coordination?

Deliberate person-centred organisation of patient care activities between providers to facilitate self-management, appropriate care, health outcomes and greater efficiency. Patients enrolled into the integrated care program are monitored and supported for the duration of the intervention. A key aim is to empower patients to self-manage, understand their illness, and seek additional support and intervention when required.

This includes:
- developing and implementing an integrated care plan with the consumer
- helping the consumer understand and self-manage their conditions
- working with organisations to support the consumer in the community
- improving the appropriateness, coordination and consistency of services
- enhancing choice and flexibility in service delivery
- improving service efficiency and patient outcomes

Source(s): https://aci.health.nsw.gov.au/resources/primary-health/consumer-enablement/guide/how-to-supportenablement/care-coordination; https://www.health.nsw.gov.au/integratedcare/Pages/chronic-conditions.aspx

What is care navigation?

People living with chronic conditions often need access to multiple health services, numerous assessments and advice from different care providers. Dealing with different health services and facing unfamiliar people and places can often be confusing, especially for people who are sick and vulnerable. Without someone to help them navigate the health system, there is a risk that these people will disengage and fall through the cracks in the system. The role for care navigation is to facilitate access to services for the care of a patient, their carers and family for a defined episode of care.
The aim of care navigation is to:
- improve the timeliness and appropriateness of care
- reduce barriers to access to care
- reduce failure to follow up
- support patients to navigate the health system
- reducing unplanned admission to hospital.

Source(s): https://aci.health.nsw.gov.au/resources/primary-health/consumer-enablement/guide/how-to-supportenablement/care-navigation; https://www.health.nsw.gov.au/integratedcare/Pages/chronic-conditions.aspx

What is health coaching?
A patient-centred approach to goal-setting, active learning and self-management that guides, empowers and motivates an individual to change their behaviour. Health coaching programs support patients to modify their own behaviour, self-manage and monitor their chronic conditions and medications.

Source: https://www.health.nsw.gov.au/integratedcare/Pages/chronic-conditions.aspx

What is usual care?

No issues or risks have been identified during initial assessment. Patients are well supported by their GP and family, have services and supports in place (e.g. My Aged Care, NDIS), are managing well at home, and no other services and/or care is required.