

**CHRONIC DISEASE MANAGEMENT  
COMBINED  
PREPARATION OF A GP MANAGEMENT PLAN (GPMP) (MBS ITEM NO. 721) &  
COORDINATION OF TEAM CARE ARRANGEMENTS (MBS ITEM NO. 723)**

**SAMPLE FORMS**

<b>Date these services were provided:</b>	
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<b>Patient's name and address:</b>	
<b>Date of Birth:</b>	
<b>Contact Details:</b>	
<b>Medicare No.</b>	
<b>Private health insurance details, if applicable:</b>	

<b>Details of patient's usual GP:</b>	<b>Details of patient's carer (if applicable):</b>

<b>If the patient has a previous or existing care plan, when was it prepared and what were the outcomes:</b>

<b>Other notes or comments relevant to the patient's care planning:</b>

<b>Medications:</b>

<b>Allergies:</b>

**Patient's Name:**

**I have explained the steps and costs involved, and the patient has agreed to proceed with the service**

(GP's signature and date)

**PREPARATION OF A GP MANAGEMENT PLAN (ITEM 721)**

<b>Patient's health problems / health needs / relevant conditions</b>	<b>Management goals with which the patient agrees</b>	<b>Treatment and services required, including actions to be taken by the patient</b>	<b>Arrangements for providing treatment/services (when, who, contact details)</b>

**Copy of GPMP offered to patient? YES**

**Copy / relevant parts of the GPMP supplied to other providers? YES / NO / NOT REQUIRED**

**GPMP added to the patient's records? YES**

**Review date for this plan: dd/ mm / yy**

**Patient's Name:**

**I have explained the steps and costs involved, and the patient has agreed to proceed with the service**

(GP's signature and date)

**COORDINATION OF TEAM CARE ARRANGEMENTS (ITEM 723)**

**Treatment and service goals for the patient / changes to be achieved**

**Treatment and services that collaborating providers will provide to the patient**

**Actions to be taken by the patient**

**Copy of TCAs offered to patient? YES**

**TCAs added to the patient's records? YES**

**Review date for these TCAs: dd/ mm / yy**

**Copy / relevant parts of the TCAs supplied to other collaborating providers? YES / NO / NOT REQUIRED**

**Referral forms for Medicare allied health services completed? YES / NO**  
(for referral forms call 02 6289 4297 or go to [www.health.gov.au/epc](http://www.health.gov.au/epc))