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| 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 and Aged Care 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 | | | |  |  |  |  | |  |  |  | |  |  |  | |  | |  |  |  |  | |  |  |  |  | |  | | |  | | | | |  | | |  | | | | | | |
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| Name | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | |  |
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| Address | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Postcode | | |  |
| Patient details | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Medicare Number | | | |  |  |  |  | |  |  |  | |  |  |  | |  | |  |  |  |  | |  |  |  |  | |  | | | Patient’s ref no. | | | | | |  | | | Patient’s DOB.\_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_ | | | | | |  |
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| First Name | | | |  | | | | | | | | | | | | | | | | | | | | | | | | |  | | | Surname | | | | | |  | | | | | | | |  |
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| Address | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Postcode | | |  |
| Allied Health Provider (AHP) patient referred to: (Please specify name or type of AHP) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Name | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | |
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| Address | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Postcode | | |  |
| 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 | | | |  | |  | | | | | 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 | |  | | |  | | |  | | |  |  |
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| **Referring General  Practitioner’s signature** | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | |  | | | | |  | | | | | | | | |  | | |
| Date signed | | | | |  | | | | | | | | |  | | |
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| 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 Services Australia (Medicare) audit purposes. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| This form may be [downloaded from the Department of Health and Aged Care website](https://www.health.gov.au/resources/publications/referral-form-for-chronic-disease-allied-health-services-under-medicare). | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **THE FORM DOES NOT HAVE TO ACCOMPANY MEDICARE CLAIMS** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |