CHRONIC CARE COORDINATION REFERRAL

BDAC
BENDIGO & DISTRICT
ABORIGINAL CO-OPERATIVE

Referral Date: _____ Feedback requested: ☐ Yes ☐ No

Patient details	
Name:	Preferred name/s:
Date of Birth:	Gender: Male Female
Address:	
Phone:	
Alternate Contact Name: Phone:	

Program Eligibility	
☐ Aboriginal and/or Torres Strait Islander	
☐ Current GP Care Plan (please attach)	
Evidence of one of more of the following:	
☐ Cancer	☐ Cardiovascular Disease
☐ Chronic Renal (Kidney) Disease	☐ Chronic Respiratory Disease
☐ Diabetes	☐ Mental health
☐ Other:	
Priority: ☐ Urgent (list reason) ☐ Non-urgent	

Referrer details	
GP Name:	Provider Number:
Practice Name:	
Phone:	
Address:	
Practice Nurse Contact Details:	

Other notes
E.g. Current Services

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Clinical information
Warnings: Allergies:

Current medication	
Drug name	Dose/frequency

Medical history

Social history

Attachments
Investigation/Test results/Relevant plans: (GP Management Plan, Team Care Arrangement, Mental Health Treatment Plan)

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