

**GENERAL PRACTITIONER REFERRAL FORM**

***Dietitian-based programs for chronic disease***

***management including group interventions.***

**APD PROVIDER DETAILS:**

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|  Patient has GP Management Plan (item 721 or review item 732) AND Team Care Arrangements (item 723 or review item 732) |
|  GP has contributed to or reviewed a multidisciplinary care plan prepared by the patient’s aged care facility (item 731) |
| Patient has been allocated (enter amount up to five) Dietitian services with item number 10954 that are eligible for Medicare rebates this calendar year |
| **Note:** GPs are encouraged to attach a copy of the relevant part of the patient’s care plan to this form. |

**PATIENT DETAILS:**

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| **Title:** \_\_\_\_\_\_\_\_\_\_\_\_\_**Surname:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Given name:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Date of Birth:** \_\_\_\_/\_\_\_\_/\_\_\_\_**Sex:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Postcode:**\_\_\_\_\_\_\_\_\_\_\_**Phone:** (H)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(M)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Medicare No:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Patient Reference No:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  **CLINICAL INFORMATION:**I would like your assistance in developing an appropriate nutrition program specific to their current medical, physical or other needs. I would like to draw your attention to this patient’s current medical condition:In my opinion, the above patient is suitable to participate in a dietetic consultation/dietitian-based program; however, I understand that you will undertake a thorough assessment to ensure your prescription meets their current health needs.I would appreciate a summary of your recommendations being forwarded to me after the first and last service, and more often if clinically necessary. |
| **REFERRING GENERAL PRACTITIONER** **SIGNATURE:** ..........................................................**DATE:** \_\_\_\_/\_\_\_\_/\_\_\_\_ | REFERRING GENERAL PRACTITIONER DETAILS (place stamp here): |