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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 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 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Name |  |  |  |
|  |  |  |
| Address |  | Postcode  |  |
| Patient details |
| Medicare Number |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | Patient’s ref no. |  |  Patient’s DOB.\_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_ |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| First Name |  |  | Surname |  |  |
|  |  |  |  |  |  |
| Address |  | Postcode  |  |
| Allied Health Provider (AHP) patient referred to: (Please specify name or type of AHP)  |
| Name | Veronica Lindqvist. 502262AT- Allied Exercise Physiologist  |  |
|  |  |  |  |  |
| Address | 2/12 William Street Coolum Beach – Mobile 0416 257 721 Email evolvept@gmail.com | eFax 61 7535 76050 |  |
| Referral details – Please use a separate copy of the referral form for each type of serviceEligible 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 |  |  |  |  |  |
|  |  |  |  |  |
| **Referring General Practitioner’s signature** |  |  |  |  |
| Date signed |  |  |
|  |  |  |  |  |
| 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 Department of Human Services (Medicare) audit purposes. |
| This form may be downloaded from the Department of Health website at [www.health.gov.au/mbsprimarycareitems](http://www.health.gov.au/mbsprimarycareitems) |
| **THE FORM DOES NOT HAVE TO ACCOMPANY MEDICARE CLAIMS** |

 Exercise Physiologist - Veronica Lindqvist. 502262AT mobile 0405 523 347 Email.evolvept@gmail.com

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