



Referral to:

Integrated Team Care Program Aboriginal Health Service NSLHD

Fax (02) 9462 9083

Or scan and email to:

Leanne Fisher Leanne.Fisher@health.nsw.gov.au

Or

Molly Florance Mary.florance@health.nsw.gov.au

Thank yo	u for s	eeing:
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Clien	t Name	Date of Birth	
Addr	ess —	Suburb	
Home Phone Mobile			
Email			
My cl	ient fulfills thi	s criteria (Please tick)	
Identifies as Aboriginal and/or Torres Strait Islander and has given me verbal or written consent to participate in this program and his/her GP Management Plan is attached.			
Has a chronic condition including but not limited to Cancer, Cardiovascular disease, Diabetes, Renal disease, Respiratory disease and mental health condition. Chronic disease must be in in a severe form.			
Pleas	e identify Chr	onic disease condition below	
	I have attach	ed clients GP Management Plan and or Team Care Arrangement.	
I have attached relevant clinical history including current medications.			
Refer	ring GP	Date	
GP P	hone number		
Comr	ments on Pati	ents Condition	

I acknowledge and pay my respects to Aboriginal and Torres Strait Islander people past, present and future as custodians of all Country in Australia