Marrabinya Referral Form

1800 940 757

To be eligible for the service, Indigenous patients must be enrolled for chronic disease management in a general practice in Broken Hill, Balranald, Central Darling or Wentworth LGAs or Unincorporated Far West NSW.

A new referral is required annually. A new referral is also required for each new service requested. However, patients are only required to consent once.

Practice Details

Practice Name:		
Practice Address:		
Email:		
Phone Number:		
Fax Number:		
Practice Contact Worker:		
Referring GP:		
GP Type:	☐ Locum GP	☐ Regular Practice GP

Patient Details

Is this an existing Marrabinya patient? ☐ Yes ☐ No

Name:			
Address:			Medicare No.:
			Health Care Card No.:
Date of Birth:			Pension Card No.:
Phone Number:	Home:	Mobile:	Concession Card No.:
Next of Kin Contact:	Name:		Phone:

Does this patient identify as Aboriginal or Torres Strait Islander? To be eligible for this service, patients must be Indigenous.
Note: we may seek confirmation of Aboriginality.

☐ Yes ☐ No (patient is not eligible)

Is this patient enrolled for chronic disease management in your general practice and does the patient have a current GPMP (< 12 months)?

☐ Yes ☐ No (patient is not eligible for support) Billing Date:..

Please indicate patient's Chronic Disease *(NB: private dental services are not covered):*

☐ Diabetes ☐ Cardiovascular Disease ☐ Chronic Respiratory Disease
☐ Chronic Kidney Disease ☐ Cancer ☐ Liver Disease
☐ Musculoskeletal condition (osteoarthritis, inflammatory arthritis, osteoporosis)

Services Required

☐ Travel (i.e. fuel, transport and accommodation) ☐ Assistance with cost of appointment
☐ Medical Aid – Supplier and aid type:..

– Instructions / Comments (e.g. level of urgency): ....

Referral Date:.. GP Signature: ....

*** Please detail all Specialist Appointments over Page ***

Once completed please fax referral to: 08 8082 9889 or email: marrabinya@maarima.com.au

REVISED FORM DATE 03/01/2023

Specialist and Allied Health Appointment Details – Please list all appointments

Specialist's Name:..

Specialist's Address:..

Specialist's Phone Number: ....

Is the appointment booked? ☐ No ☐ Yes: Date/Time:...

Speciality (Cardiologist, Podiatrist etc.): ....

Specialist's Name:..

Specialist's Address:..

Specialist's Phone Number: ....

Is the appointment booked? ☐ No ☐ Yes: Date/Time:...

Speciality (Cardiologist, Podiatrist etc.): ....

Specialist's Name:..

Specialist's Address:..

Specialist's Phone Number: ....

Is the appointment booked? ☐ No ☐ Yes: Date/Time:...

Speciality (Cardiologist, Podiatrist etc.): ....

Specialist's Name:..

Specialist's Address:..

Specialist's Phone Number: ....

Is the appointment booked? ☐ No ☐ Yes: Date/Time:...

Speciality (Cardiologist, Podiatrist etc.): ....

Specialist's Name:..

Specialist's Address:..

Specialist's Phone Number: ....

Is the appointment booked? ☐ No ☐ Yes: Date/Time:...

Speciality (Cardiologist, Podiatrist etc.): ....

Specialist's Name:..

Specialist's Address:..

Specialist's Phone Number: ....

Is the appointment booked? ☐ No ☐ Yes: Date/Time:...

Speciality (Cardiologist, Podiatrist etc.): ....

Specialist's Name:..

Specialist's Address:..

Specialist's Phone Number: ....

Is the appointment booked? ☐ No ☐ Yes: Date/Time:...

Speciality (Cardiologist, Podiatrist etc.): ....

Please copy page if more space is required.

Patient Consent and Charter – Marrabinya

Name:	
Address:	
Date of Birth:	

My GP has told me about Marrabinya and I want to participate.

I understand what I have been told and any questions I had have been answered.

I understand that services (GPs, Specialists, Aboriginal Medical Services, Hospitals, Allied Health Workers) might have to share my information for care planning and to assess my eligibility for chronic care services. I know that wherever possible you will ask for my verbal consent to share information with other services before doing so.

I understand that you may need to share my non-clinical information (like my date of birth, phone number, medicare and pension card numbers) with health and non-health organisations (like travel agents) in order to arrange services on my behalf. I know that you will only do this where it is necessary for my care and that you will make every effort to ensure my non-clinical information is kept confidential.

I know that I can withdraw this consent at any time. To withdraw my consent, I must send a written note to Marrabinya. The withdrawal will be valid as soon as Marrabinya gets my note, but will not apply to information that has been shared since my initial consent.

I agree that some information about me (but not my name) will be kept and used so that you can improve the way care is provided to Indigenous people.

As a patient accessing Marrabinya you have a right to:

- access services that meet your health care needs.
- receive safe and high quality health services, provided with professional care, skill and competence.
- receive open, timely and appropriate communication about your health care in a manner you can understand.
- join in making decisions and choices about your care.
- assume that the care provided will be respectful of you and your culture, beliefs and personal needs and requirements.
- assume that your personal privacy is maintained and proper handling of your personal health and other information is assured.
- comment on or complain about your care and have your concerns investigated and responded to.

In return you have a responsibility to:

- advise us of any changes to your contact details.
- keep your appointments, or notify us if you are unable to attend.
- provide accurate information about your health and anything else that may have an impact on your care.
- be as open and honest as you can, and ask for more information if you do not understand.
- ask questions so you can learn about your condition and your care options before giving your consent to any treatment.
- discuss your concerns and decisions with your health care provider.
- treat all staff and others with respect and dignity.
- accept that your health information may be shared with appropriate health care providers and other agencies as authorised by law.
- ask for your recorded health information to be corrected if it is inaccurate.
- respect the privacy and confidentiality of others.

Patient Name:	
Signature:	
Date:	

I have discussed this referral to the service with the patient and I am satisfied that the patient understands and is able to provide informed consent to this.

Health Professional Name:	
Designation:	
Signature:	
Date:	