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 or an Aboriginal Community Controlled Health Organisation (ACCHO).

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

Practice Details

Practice/ACCHO Name:		
Practice/ACCHO 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:		
Date of Birth:		Medicare No.:
Phone Number:	Home:	Mobile:
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 or ACCHO 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

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): ....

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

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

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

REVISED FORM DATE 12/11/2018

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 know that I can withdraw this consent at any time. To withdraw my consent, I must send a written note to my Chronic Care Link Worker. The withdrawal will be valid as soon as the Worker 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 to sign and Clinical Support to confirm they agree with this.

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:	