What you should expect to receive back from the service

Level 1, 2 +3 Patients will have care plans developed. You will be provided with:

- Receipt of referral and indication of when assessment has been arranged
- Notification if your patient does not attend for the assessment appointment
- Outcome of assessment process, details of care plan and other referrals
- Ongoing progress reports
- Notification if patient is discharged from the service.

Level 4 Patients will be provided with support for lifestyle change through individual or group sessions.

You will be provided with:

- Receipt of referral and indication of the program your patient is being provided
- Notification if your patient does not attend for session
- Progress reports, information on other referrals
- Notification when client has completed the program/ sessions.

Organisations involved in the initiative include:

- Banyule Community Health
- Nillumbik Community Health Service
- Darebin Community Health
- Austin Health HARP programs
- Northern Health HARP programs
- Royal District Nursing Service

We are committed to providing a more proactive, comprehensive and integrated service for people with chronic disease in our region and aim to ensure that our services and processes support general practice to fully utilise MBS chronic disease care items.

Austin Health

BANYULE Community Health

DAREBIN community health

Nillumbik Community Health Service

Northern Health

Royal DistrictNursing Service
Bringing healthcare to you

Supported by:

NEPCP Partnership For Healthy Communities

medicare local NORTHERN MELBOURNE
Connecting health to meet local needs

Service Providers in Banyule, Nillumbik and Darebin	PHONE:
Austin Health	9496 2834
Banyule Community Health	9450 2000
Darebin Community Health	8470 1111
Nillumbik Community Health Service	9430 9100
Northern Health	9495 3109
Royal District Nursing Service	1300 687 7464

Living with a Chronic Condition

Getting the right help, in the right place at the right time for your patients

Find the service in Banyule, Nillumbik and Darebin that meets the needs of your patient in one referral process.

Getting the right help, in the right place at the right time for your patients

To help General Practitioners match patient needs with the appropriate service, referral and access to programs for people with chronic disease have been streamlined.

How to use the streamlined referral process

Identify the level of care your patient needs and the location that is easiest for them to access (see table):

- call,
- fax or
- suggest your patient call

and ask for an appointment with the service you have identified as appropriate.

Services for people with chronic conditions include...

The General Practice Referral Template (formally known as the VSRF) provides a standardised quality referral from general practice to other service providers and is the preferred template.

The General Practice Referral template is available at: http://docs.health.vic.gov.au/docs/doc/General-practice-referral

It is possible for General Practitioners to use the following MBS items in combination with a referral to these services:

- GPMP 721 or Review 732
- TCA 723 or Review 732
- 45 – 49 Health Check 701 (brief), 703 (standard), 705 (long). 707 (prolonged)
- 40 – 49 Diabetes Risk Evaluation 701 (brief), 703 (standard), 705 (long). 707 (prolonged)
- Aboriginal and Torres Strait Islander Health Assessment 715
- Various Case Conferencing MBS items are also available

LEVEL OF CARE	DESCRIPTION	ORGANISATIONS PROVIDING SERVICE	CONTACT NUMBER
Level 1+2 **Patient uses hospitals frequently or is at imminent risk of hospitalisation.** eg. Heart Failure, Diabetes, COPD, lacks social support or condition is unstable. Note: not all medical conditions are accommodated in these programs	For people with complex problems requiring: • Intensive care coordination • Comprehensive assessment and care planning • Specialist medical and GP management • A package of services • Continuous, frequent interventions • Linkage to ongoing monitoring and maintenance • Support with Self-management interventions lifestyle change	Austin Health HARP programs	**PHONE:** 9496 2834 **FAX:** 9496 4337 GP Referral Template preferred
		Royal District Nursing Service	**PHONE:** 1300 687 7464 **FAX:** 1300 657 265 GP Referral Template preferred
		Northern Health HARP Programs	**PHONE:** 9495 3109 **FAX:** 9467 8698 GP Referral Template preferred
Level 3 **Patient requires education about their condition, support with lifestyle changes, psychosocial and/or allied health treatment.**	For people with a chronic condition requiring: • Assessment and care planning • Information about their condition • Support with Self-management interventions lifestyle change	Royal District Nursing Service	**PHONE:** 1300 687 7464 **FAX:** 1300 657 265 GP Referral Template preferred
		Banyule Community Health	**PHONE:** 9450 2000 **FAX:** 9459 5808 GP Referral Template preferred
		Nillumbik Community Health Service	**PHONE:** 9430 9100 **FAX:** 9431 0339 GP Referral Template preferred
		Darebin Community Health	**PHONE:** 8470 1111 **FAX:** 8470 1813 GP Referral Template preferred
Level 4 **Patient requires support with adopting healthy lifestyle behaviours**	For people at risk of, or with, a chronic disease who are not requiring level three type intervention but seeking support with adopting healthy lifestyle behaviours Ideal referral pathway to support Lifescript interventions Access smoking cessation, healthy eating or physical activity programs	Banyule Community Health	**PHONE:** 9450 2000 **FAX:** 9459 5808 GP Referral Template preferred
		Nillumbik Community Health Service	**PHONE:** 9430 9100 **FAX:** 9431 0339 GP Referral Template preferred
		Darebin Community Health	**PHONE:** 8470 1111 **FAX:** 8470 1813 GP Referral Template preferred