

**TOOLS**

**Shared Transfer of Care Method**

person with the treatment/

plan



Contact provider to check

48 hours to check progress

[**www.primaryhealthtas.com.au**](http://www.primaryhealthtas.com.au/)

**Shared Transfer of Care**

**TRANSFER**

**ENGAGE**

**PREPARE**

**CONSULT**

**GATHER**

**ORGANISE**

 Receive referral

 Verbal communication with referrer to clarify

any questions

 Any other information available

 Who else has been involved?

 Have previous assessments been completed, and can you obtain a copy?

 Make sense of the information

 Discover the story

**CONNECT**

**GOALS**

**AGREEMENT**

 Connect with the person

 Discover the person’s story

 Identify important relationships

 Clarify information received

 Build upon assessment

(if required)

 Listen to the person’s goals and concerns

 Identify the person’s strengths and the strengths of the people around them

 What goals are achievable for the person

 With all the gathered information, provide the

care options

 Through shared decision- making, create an agreed

 Provide time for the person to consider the plan and ask further questions

**PLAN**

**SHARE/CONSULT**

**FOLLOW-UP**

 Generate the plan: complete referrals, gather information

 Document the plan: include contact details of services

 Check in with the

person to ensure the plan meets the agreed goals and concerns

 Allow time for the person to ask questions

 Email/fax referral to appropriate provider or platform (i.e. My Aged Care Gateway) and general practitioner

 Follow up referral with phone call to clarify any questions

 Give written plan to person, and ensure they understand

 Ensure plan contains contact details for person and providers to call back if issues arise

on progress

 Contact person within

(if organisational policies allow)