

Referral to:

**Integrated Team Care - Care Coordination**

Circular Head Aboriginal Corp

PO Box 335

Smithton TAS 7330

Phone: (03) 6452 1287

Mob: 0400 861 550

Fax: (03) 6452 1187



Thank you for seeing:

Patient Name:

Date of Birth:

Mobile:

Email:

**My patient identifies as Aboriginal, has given me verbal or written consent to participant in this program?**

**My Patient has one or more of the following chronic diseases:**

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**I have attached the patients GP Management Plan or Team Care Arrangements Plan or any relevant Clinical history, including medications:**

Referring GP Signature:	Date:
GP Name: <DrName>	Phone Number:
Comments on Patients Condition:	Any other relevant information: