Referral to:

Integrated Team Care Program
Aboriginal Health Service NSLHD

Fax (02) 9462 9083

Or scan and email to:
Leanne Fisher Leanne.Fisher@health.nsw.gov.au
Or
Molly Florance Mary.florance@health.nsw.gov.au

Thank you for seeing:

Client Name		**Date of Birth**	
Address		**Suburb**	
Home Phone		**Mobile**	
Email			

My client fulfills this criteria (Please tick)	
☐	Identifies as Aboriginal and/or Torres Strait Islander and has given me verbal or written consent to participate in this program and his/her GP Management Plan is attached.
☐	**Has a chronic condition including but not limited to Cancer, Cardiovascular disease, Diabetes, Renal disease, Respiratory disease and mental health condition.** **Chronic disease must be in in a severe form.**
Please identify Chronic disease condition below	
☐	I have attached clients GP Management Plan and or Team Care Arrangement.
☐	I have attached relevant clinical history including current medications.
Referring GP	**Date**
GP Phone number	
Comments on Patients Condition	

I acknowledge and pay my respects to Aboriginal and Torres Strait Islander people past, present and future as custodians of all Country in Australia

Northern Sydney Local Health District
Aboriginal Health Service
ABN 63 834 171 987

RNS Community Health Building
2C Herbert Street
St Leonards NSW 2065
Tel (02) 9462 9017 Fax (02) 9462 9083