MDT Referral Form

The Multidisciplinary Team (MDT) Program aims to reduce hospitalisations and improve health outcomes for people with **diabetes, cardiac disease and chronic pulmonary disease** in **Darwin** and **Alice Springs** regions.

Clients are eligible for:

- Up to 10 Fully Funded Allied Health Sessions
- Care Coordination through the Program's System Navigator
- Access to the *Support Service* program e.g. physical activity program

Eligibility	
Please confirm that the person meets <u>all</u> the eligibility criteria: *Select all criteria that they meet*	☐ Lives in Darwin or Alice Springs regions and holds a valid Medicare card ☐ Has diabetes, pulmonary disease and/or cardiac disease ☐ Is at high risk of escalation or progression of one or more of their chronic conditions in the next 24 months ☐ Holds a current Health Care card, Low Income Health Care card, Pension card or meets the below financial hardship criteria: • Recent loss of employment but does not yet have the required documentation • Experiencing family violence • Experiencing homelessness, housing insecurity or living in crisis accommodation ☐ Is willing and has support from their GP to participate in the MDT Program

Referrer (stamp accepted)		
Referral date: *DD/MM/YYYY*		
Referring General Practitioner:		
Referring organisation/ General Practice:		
Contact details:		
Client Details		
Full Name:		
Date of birth: *DD/MM/YYYY*		
Gender:		
Do they identify as Aboriginal and/or Torres Strait Islander?	☐Aboriginal ☐Torres Strait Islander	☐Both ☐Neither
Client/Contact Phone Number:		
Client/Contact Email Address:		
Postal Address:		
Does the client have an existing care coordinator? (example: NDIS or MyAged Care Navigator)	☐No ☐Yes	

Applicable Allied Health Services

Eligible clients may access **up to 10** fully funded allied health services within a 12-month period. Please indicate which professions you recommend for multidisciplinary team care for this client.

☐ **Dietetics**	☐ **Diabetes Education**	☐ **Physiotherapy**	☐ **Psychology**
☐ **Occupational Therapy**	☐ **Exercise Physiology**	☐ **Podiatry**	

Checklist

☐ Attach GP Referral Letter

☐ Attach relevant investigation/pathology results

Comments (include any relevant comments in relation to barriers accessing care or additional requirements this client may have)

Please send the completed form and attachments to:

MDT Program System Navigator

Fax: 08-8927 8515

E: MDT@healthylivingnt.org.au