CHRONIC DISEASE MANAGEMENT
COORDINATION OF TEAM CARE ARRANGEMENTS (TCAs)
(MBS ITEM NO. 723)

SAMPLE FORM

Date service was provided:	

Patient's name and address:	
Date of Birth:	
Contact Details:	
Medicare No.	
Private health insurance details, if applicable:	

Details of patient's usual GP:	**Details of patient's carer (if applicable):**

If the patient has a previous or existing care plan, when was it prepared and what were the outcomes:

Other notes or comments relevant to the patient's care planning:

Medications:

Allergies:

Patient's Name:

I have explained the steps and costs involved, and the patient has agreed to proceed with the service (GP's signature and date)

COORDINATION OF TEAM CARE ARRANGEMENTS (ITEM 723)

Treatment and service goals for the patient / changes to be achieved	**Treatment and services that collaborating providers will provide to the patient**	**Actions to be taken by the patient**

Copy of TCAs offered to patient? YES / NO

Copy / relevant parts of the TCAs supplied to other collaborating providers? YES / NO / NOT REQUIRED

TCAs added to the patient's records? YES / NO

Referral forms for Medicare allied health services completed? YES / NO
The referral form issued by the Department can be found at www.health.gov.au/mbsprimarycareitems or a form can be used that contains all of the components of the Department's form.

Review date for these TCAs: dd/ mm / yy