

STEPP PATIENT REFFERAL (Telehealth available)

The STEPP program (*full multi-disciplinary program for patients **with chronic pain***)

Patient Name	Date of Birth
Address	Phone number
Email address	Claim number (if required)
Diagnosis and relevant history	

WORKERS COMPENSATION REFFERAL (if relevant)

- ☐ I have included a copy of the Certificate of Capacity, with a referral to the **STEPP program** in the management section. STEPP will send a request to the insurer when the patient supplies their claim number and insurer details.

PRIVATE REFERRAL WITH MEDICARE REBATE (for the STEPP program, there are out of pocket expenses)

- ☐ This patient will attend the **Psychology** portion of the STEPP program using the Mental Health Care plan which is attached. (*Medicare will partially fund sessions*)
- ☐ This patient will attend the **Physiotherapy** portion of the STEPP program under the Chronic Disease Management program. *Medicare will partially fund up to 5 sessions* (item 10960). **This requires completion of a GP Management Plan and a CDM referral form located at the end of this referral.
- ☐ The patient is aware that there are *out-of-pocket expenses for both services* and can download fees from the website.

Doctor's name and provider number

Doctor's signature

Practice

contact number

Client information:

Please email admin@stepp.com.au or phone 0478 045 617 and leave a message and we will contact you regarding getting approval or making an appointment.



Referral Form for Individual Allied Health Services under Medicare for patients with a chronic medical condition and complex care needs

Note: GPs can use this form issued by the Department of Health or one that contains all of the components of this form.

To be completed by referring GP:

Please tick:

- ☐ Patient has GP Management Plan (item 721) AND Team Care Arrangements (item 723) OR
☐ GP has contributed to or reviewed a multidisciplinary care plan prepared by the patient's aged care facility (item 731)

Note: GPs are encouraged to attach a copy of the relevant part of the patient's care plan to this form.

GP details

Provider Number

Name

Address Postcode

Patient details

Medicare Number Patient's ref no.

First Name Surname

Address Postcode

Allied Health Provider (AHP) patient referred to: (Please specify name or type of AHP)

Name Dr Rowena Field

Address 66B Collins St, Kiama NSW 2533 Postcode

Referral details – Please use a separate copy of the referral form for each type of service

Eligible patients may access Medicare rebates for a maximum of 5 allied health services (total) in a calendar year. Please indicate the number of services required by writing the number in the 'No. of services' column next to the relevant AHP.

No of services	AHP Type	Item Number	No of services	AHP Type	Item Number	No of services	AHP Type	Item Number
	Aboriginal Health Worker/Aboriginal and Torres Strait Islander Health Practitioner	10950		Exercise Physiologist	10953		Podiatrist	10962
	Audiologist	10952		Mental Health Worker	10956		Psychologist	10968
	Chiropractor	10964		Occupational Therapist	10958		Speech Pathologist	10970
	Diabetes Educator	10951		Osteopath	10966			
	Dietitian	10954		Physiotherapist	10960			

Referring General Practitioner's signature

Date signed

The AHP must provide a written report to the patient's GP after the first and last service, and more often if clinically necessary.

Allied health providers should retain this referral form for record keeping and Medicare Australia audit purposes.

This form may be downloaded from the Department of Health website at www.health.gov.au/mbprimarycareitems

THE FORM DOES NOT HAVE TO ACCOMPANY MEDICARE CLAIMS