<<Miscellaneous:Practice Letterhead>>

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| **TEAM CARE ARRANGEMENTS - MBS ITEM No 723 (ATRIAL FIBRILLATION)** |

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| **Patient’s Name:** <<Patient Demographics:Full Name>> | **Date of Birth:** <<Patient Demographics:DOB>> |

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| **Contact Details:** | **Medicare or Private Health Insurance Details:** |
| <<Patient Demographics:Full Address>> | <<Patient Demographics:Medicare Number>>  <<Patient Demographics:Health Insurance>> |

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| **Details of Patient’s Usual GP:** | **Details of Patient’s Carer (if applicable):** |
| <<Doctor:Name>>  <<Doctor:Full Address>> |  |

**Date of last Care Plan/Team Care Arrangements (if done):**  [<<Date of last Care Plan/TCA>>](##CUSTOM#|D|||10|  /  /    )

**Other notes or comments relevant to the patient’s Team Care Arrangements:**

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**PAST MEDICAL HISTORY**

**FAMILY HISTORY**

<<Clinical Details:Family History>>

**MEDICATIONS**

<<Clinical Details:Medication List>>

**ALLERGIES**

**Patient’s Name:** <<Patient Demographics:Full Name>>

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| **TEAM CARE ARRANGEMENTS - MBS ITEM 723 (ATRIAL FIBRILLATION)** |

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| **Goals - changes to be achieved** | **Required treatments and services including patient actions** | **Specific arrangements for treatments/services (when, who, and contact details)** |
| Patient to have a clear understanding of atrial fibrillation and the patient's role in managing the condition | Patient education | GP  Practice nurse  e-tools |
| Stroke prevention plan- review of CHA2DS2-VASc score | Patient education – annual reassessment if not on anticoagulant | GP/Cardiologist / e-tools |
| Strategy of rhythm control (aim to maintain sinus rhythm) where applicable | Referral and regular review by Cardiologist / Electrophysiologist for rhythm control options | Cardiologist / Electrophysiologist |
| Monitor cardiac function | Regular echocardiogram testing | GP / Cardiologist |
| Medication management | Ensure correct use of medications. Undertake Home Medicine Review | GP / Cardiologist  Pharmacist |
| Maintain healthy diet and optimum weight range (including lifestyle aspects of lipids and blood pressure) | Maintain healthy nutrition and weight control | GP  Dietitian  Other allied health educator |
| Maintain physical activity | Development of exercise program suitable to needs of patient | GP  Cardiac rehab  Exercise physiologist  Other allied health educator |
| Avoid alcohol excess | Patient education | GP |
| Minimise ongoing cardiac symptoms | Optimise medical management / rhythm control treatments | GP  Cardiologist or Electrophysiologist |
| Co-morbidity, e.g. hypertension, OSA | Optimise medical management | GP  Medical specialist |
| Improve wellbeing | Manage depression | GP  Psychologist/psychiatrist/counsellor |
| Reduce social isolation | Linkages to community services | GP  Counsellor/social worker |

**Copy of Team Care Arrangements offered to patient?**  [<<Copy of TCA offered to patient?>>](CUSTOM#|B|||1|N)

**Team Care Arrangements added to the patient’s records?** [<<TCA added to patient record?>>](CUSTOM#|B|||1|N)

**Copy / relevant parts of the Team Care Arrangements supplied to other providers?** [<<Copy of TCA supplied to other providers?>>](CUSTOM#|B|||1|N)

**Referral forms for Medicare allied health and dental care services completed?** [<<Referral forms for Medicare AHPs completed?>>](CUSTOM#|B|||1|N)

[For referral forms call 1800 067 307, go to www.hic.gov.au/providers/forms or look under "Supplied" templates]

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| **Date service was completed:** [<<Date service completed>>](##CUSTOM#|D|||10|  /  /    ) | **Proposed Review Date:** [<<Review date (6 months recommended)>>](##CUSTOM#|D|||10|  /  /    ) |

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| **I have explained the steps and any costs involved, and the patient has agreed to proceed with the Team Care Arrangements.** [<<Steps and costs explained, patient agreed>>](CUSTOM#|B|||1|N)  **The patient also agrees to the involvement of other health providers and to share their clinical information (without / with restrictions).**  [<<Patient agrees to AHPs and sharing information>>](##CUSTOM#|L|||51|Yes, without restrictions|Yes, with restrictions|No)  GP’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |