South Western Sydney Local Health District

Facility: Primary & Community Health

FAMILY NAME	MRN
GIVEN NAME	☐ MALE ☐ FEMALE
D.O.B.	M.O.
ADDRESS	
LOCATION / WARD	
COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE	

KEEPING WELL IN COMMUNITY CARE NAVIGATION AND CARE COORDINATION REFERRAL

Date of Referral:	Patient Consent: ☐ Yes ☐ No

REFERRER DETAILS

Name: Click or tap here to enter text.	Contact Number: Click or tap here to enter text.

Service/Ward: Click or tap here to enter text.

PATIENT DETAILS

MRN/Medicare Number:	Click or tap here to enter text.

Surname: Click or tap here to enter text.	Name: Click or tap here to enter text.
Date of birth:	

Address: Click or tap here to enter text.

Contact Number: Click or tap here to enter text.

CLIENT INFORMATION

Does the patient have one or more diagnosed chronic health conditions?	☐ Yes ☐ No
Is the patient experiencing difficulty managing their chronic condition(s)?	☐ Yes ☐ No
Are there social or environmental factors impacting the patient's ability to manage their health?	☐ Yes ☐ No
Is the patient socially isolated or experiencing other vulnerabilities?	☐ Yes ☐ No
Is the patient currently linked with other services? E.g. GP, My Aged Care, NDIS, Community Health	☐ Yes ☐ No

What are the key goals or outcomes expected from the Keeping Well in Community Care Navigation and Care Coordination team involvement?:

Click or tap here to enter text.

Email referrals to: swslhd-integratedcare@health.nsw.gov.au

AMR018012

Holes Punched as per AS2828.1: 2019

BINDING MARGIN - NO WRITING

SWS6081752A 150926

KEEPING WELL IN COMMUNITY CARE NAVIGATION AND CARE COORDINATION REFERRAL AMR018.012

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What is care coordination?

Care Coordination is a person-centred approach designed to support people living with chronic conditions who often require care from multiple providers. Care Coordination supports people to manage their health more effectively in the community. It also addresses the psychological, social, and behavioural factors that can contribute to the progression of chronic illness and create barriers to accessing treatment.

Care Coordination promotes better health outcomes and empowers individuals to take an active role in managing their own care.

Goal of Enrolment

To deliver a whole of person care approach that improves health and psychosocial outcomes for patients with complex needs, supporting them in the community setting, using a coordinated approach.

What is the role of the KWIC CNCC team?

- Help patients understand and self-manage their chronic condition/s
- Support patients to set and reach their health goals
- Collaborate and communicate with the patient's healthcare team to ensure information is shared
- Contribute to care planning and targeted interventions to meet the patient's needs
- Support the patient to navigate the health and social care system
- Reduce barriers to access to care
- Reduce unplanned hospital admissions

Exclusion Criteria

- Under 16 years old
- Receiving End of Life care
- Current acute mental health episode
- Group home resident
- RACH resident
- Referral for NDIS
- Enrolled in Aboriginal Chronic Care Program
- Well utilised DVA Gold Care
- Well utilised Support at Home Program Level 7-8
- Current inpatient
- Correctional facility
- External to SWSLHD

Still unsure if the KWIC CNCC can help? Don't hesitate to contact the team on 9164 4478 to discuss further.