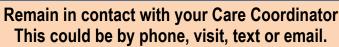
Complete Chronic Disease Management Program (CDMP) Initial Assessment





If you are contacted three (3) times, without success, you may be taken off the program



Visit your Doctor every 3-6 months to have a CDMP GP Status form completed

(ask your Doctor to email / fax a copy back to NCACCH)

Visit your doctor every 6 -12 months to have your care plan reviewed

(ask your Doctor to email / fax a copy back to NCACCH)

Visit your doctor every 9 -12 months to have your health assessment done

(ask your Doctor to email / fax a copy back to NCACCH)



As per your care plan, make an appointment and visit required Specialist and/or Allied Health Services eg. Podiatrist, diabetes / respiratory / heart / sleep specialist

(NCACCH can assist with payment if required)



Participate in the Self-Management Program

(your Care Coordinator will refer you when you are ready)

CARE COORDINATOR ROLE

- Help you understand and follow your care plan
- Help you link in with current support programs/agencies
- May contact your GP, specialist and other services to make sure you are getting the right support and service you need
- Help you and your family to self-manage your chronic condition/s
- Follow up on care plans, health assessment results and CDMP GP Status Form from your doctor

DOCTOR ROLE

- Complete a care plan for you to follow to help manage your chronic condition/s
- Refer you to specialists and allied health services relevant to your chronic condition eg. diabetes educator, podiatrist, counselling etc
- Complete the required tests regularly as per your care plan
- If registered, join you up to the "Close The Gap" program for free/cheaper medications
- Fax your completed CDMP GP Status Form to NCACCH every 3-6 months

SPECIALIST ROLE

- Specialist will assist you to understand your condition
- Give you advice on how to self-manage your condition
- Advise you whether you need to visit other specialists and/or health services
- May ask you to do further tests to help them know more about your condition
- The specialist will generally know more information about chronic disease than your GP
- The specialist will send a report on your visit to NCACCH

YOUR ROLE

- Complete and get a copy of your care plan and health assessment and ask your doctor to send a copy to NCACCH
- Visit your GP every 3-6 months and have a CDMP GP Status Form completed
- Attend specialist and allied health service appointments when required
- Keep in regular contact with your Care Coordinator (Nurse)
- Attend NCACCH self management program