**Chronic Disease Management Plan**

*MBS GP Management Plan (GPMP) and/or Team Care Arrangement (TCA)*

**PART 1 Patient Review Calendar (What needs to be done)**

Can be completed by any team member as per CARPA guidelines / CD Recall Schedules

Mark items due with / On completion mark with \ 

<table>
<thead>
<tr>
<th>CARE PLAN</th>
<th>NEW REVIEW</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
<th>April</th>
<th>May</th>
<th>June</th>
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<tbody>
<tr>
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<td>Routine clinical items (BP, Weight, Waist, BMI, BGL, UA)</td>
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<td>EUC+/- Cr Cl</td>
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<td>BGL (fasting)</td>
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See specialised plan/s for:

RHD ☐ CLD ☐ Renal ☐ Warfarin ☐ Mental Health ☐ Other ☐

**PART 4 Chronic Disease Care Plan Review**

Review as per CARPA

<table>
<thead>
<tr>
<th>Date Due</th>
<th>Note: Additional information can be written in the Progress Notes if necessary.</th>
<th>Note / Goal</th>
<th>Date completed</th>
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<tbody>
<tr>
<td>BP</td>
<td>WAIST</td>
<td>WEIGHT</td>
<td>BMI</td>
</tr>
<tr>
<td>cm</td>
<td>kg</td>
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<td></td>
</tr>
<tr>
<td>BP</td>
<td>WAIST</td>
<td>WEIGHT</td>
<td>BMI</td>
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<tr>
<td>cm</td>
<td>kg</td>
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</tr>
</tbody>
</table>

Comments / Brief Intervention:

Personal Goals – Progress made:

New plans / Goal:

Signature DMO/GP/AHW/WRN: Date completed

Review GP Management Plan 725 Y / N

Review Team Care Arrangement 727 Y / N

Annual Chronic Disease Program Plan due: 

Two yearly HIC GP Management Plan or Team Care Arrangement due: 

Note GPMPs and TCAs can be done after one year if the patient’s condition warrants it. See MBS for details.
## PART 2 Annual Review

| Date due: |  /  /  |

- **Patient Consent:**
  - Yes [ ]
  - No [ ]
  - Date of Consent: [  ]

- **GP Management Plan:**
  - Item 721 claimed: Yes [ ]
  - By Whom? [ ]

- **Women’s/Men’s Health Check:**
  - Date done: [  ]
  - Next due: [  ]

### Investigations prior to DMO/GP review

| Date: |  /  /  |

- **Lipids (fasting):**
  - Cholesterol [ ]

- **EUC:**
  - Creatinine Clearance [ ]

- **HbA1c or BGL:**
  - Renal bloods [ ]

- **FBE:**
  - LFT [ ]

- **Eye check:**
  - Foot check [ ]

- **See progress notes:**
  - Other [ ]

### Routine Clinical Examination by DMO or GP

| Date: |  /  /  |

- **Eyes:**
  - Visual acuity: [R ] [ L ]
  - Cataracts: Yes [ ]

- **Oral health:**

- **Cardiovascular:**

- **Respiratory:**
  - PEFR

- **Abdominal:**

- **Gastrointestinal:**

- **Musculo skeletal:**

- **Neurological:**

- **Renal / urological:**

### Additional investigations requested

|  |  |

### Referrals made

<table>
<thead>
<tr>
<th>Physician</th>
<th>Cardiologist</th>
<th>Optometrist</th>
<th>Dentist</th>
<th>Renal</th>
<th>Mental Health</th>
<th>Pharmacist</th>
<th>Other</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Dr’s Name:</th>
<th>Dr’s Signature:</th>
<th>Date:</th>
</tr>
</thead>
</table>

Please record clinical goals on page 3

### Risk Factors

- **S** Smoking
  - Yes / never / past smoker
  - See Progress notes [ ]

- **N** Nutrition

- **A** Alcohol / substance misuse

- **P** Physical activity

- **E** Emotional well being

#### How do these health issues affect the person and/or their family (eg major issues, difficulties)

#### Social situation (eg family support, housing, resources)

#### Personal Health Goals

<table>
<thead>
<tr>
<th>List personal goals</th>
<th>Who can help</th>
<th>Planned tasks</th>
</tr>
</thead>
</table>

#### Clinical Goals

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<th>BMI</th>
<th>BP</th>
<th>HbA1c</th>
<th>Cholesterol</th>
<th>Other</th>
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</thead>
</table>

Please record clinical goals on page 3
**PART 2**

**Annual Review**

<table>
<thead>
<tr>
<th>Patient Consent:</th>
<th>Date of Consent</th>
<th>GP Management Plan</th>
<th>Item 721 claimed</th>
<th>By Whom?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes ☐ No ☐</td>
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<table>
<thead>
<tr>
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<th>Date of Consent</th>
<th>Team Care Arrangement</th>
<th>Item 723 claimed</th>
<th>By Whom?</th>
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<tbody>
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<td>Yes ☐ No ☐</td>
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</table>

**Women's/Men's Health Check:**

<table>
<thead>
<tr>
<th>Investigations prior to DMO/GP review</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date done: _________________________</td>
</tr>
<tr>
<td>Lipids (fasting) ☐ or Cholesterol ☐</td>
</tr>
<tr>
<td>or BGL ☐ or Renal bloods ☐ or FBE ☐</td>
</tr>
<tr>
<td>See progress notes</td>
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</table>

<table>
<thead>
<tr>
<th>BP</th>
<th>Weight</th>
<th>Height</th>
<th>BMI</th>
<th>Waist circ</th>
<th>BGL</th>
<th>UA</th>
<th>Other</th>
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<tbody>
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<td>kg</td>
<td>cm</td>
<td></td>
<td>cm</td>
<td></td>
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</tr>
</tbody>
</table>

| Pneumovax 1st given: | |     |     |
|----------------------|-----------|
| Pneumovax 2nd given: | |     |     |
|                      | | Next Due: |     |

**Routine Clinical Examination by DMO or GP**

<table>
<thead>
<tr>
<th>Date: ______________________</th>
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<tbody>
<tr>
<td>Eyes:</td>
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<tr>
<td>Oral health:</td>
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<tr>
<td>Cardiovascular:</td>
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<td>Respiratory:</td>
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<td>Abdominal:</td>
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<td>Gastrointestinal:</td>
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<tr>
<td>Musculo skeletal:</td>
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<tr>
<td>Neurological:</td>
</tr>
<tr>
<td>Renal / urological:</td>
</tr>
<tr>
<td>Feet</td>
</tr>
<tr>
<td>Use diabetic foot check when indicated</td>
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<table>
<thead>
<tr>
<th></th>
<th>Pulses</th>
<th>Skin integrity</th>
<th>Sensation</th>
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<tr>
<td>Right foot</td>
<td>Yes ☐</td>
<td>No ☐</td>
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<tr>
<td></td>
<td></td>
<td>intact ☐</td>
<td>Normal ☐</td>
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</tbody>
</table>

|            | Yes ☐  | No ☐           |             |
|            |        | intact ☐       | Normal ☐   |

|            | Yes ☐  | No ☐           |             |
|            |        | intact ☐       |             |

|            | Yes ☐  | No ☐           |             |
|            |        | intact ☐       |             |

**Additional investigations requested**

- 

**Referrals made**

<table>
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<tr>
<th>Physician</th>
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<th>Renal</th>
<th>Mental Health</th>
<th>Pharmacist (Item 900)</th>
<th>Other</th>
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<table>
<thead>
<tr>
<th>Dr's Name:</th>
<th>Dr's Signature:</th>
<th>Date:</th>
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</thead>
</table>

**Please record clinical goals on page 3**

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**PART 3**

**Personal Health Story**

*Can be completed by any team member.*

<table>
<thead>
<tr>
<th>Date due:</th>
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**Risk Factors**

<table>
<thead>
<tr>
<th>Smoking</th>
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<tr>
<td>Yes / never / past smoker</td>
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<tr>
<th>Emotional well being</th>
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**How do these health issues affect the person and/or their family (eg major issues, difficulties)**

- 

**Social situation (eg family support, housing, resources)**

- 

**Personal Health Goals**

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**Clinical Goals**

<table>
<thead>
<tr>
<th>Waist</th>
<th>Weight</th>
<th>BMI</th>
<th>BP</th>
<th>HbA1c</th>
<th>Cholesterol</th>
<th>Other</th>
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<tr>
<th>Date due:</th>
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</table>
### Chronic Disease Management Plan

#### MBS GP Management Plan (GPMP) and/or Team Care Arrangement (TCA)

**PRINCIPAL NAME**

**OTHER NAMES**

**HRN**

**COMMUNITY** (List other residential communities)

- **FEMALE**
- **MALE**
- **D.O.B.**

### PART 1 Patient Review Calendar (What needs to be done)

Can be completed by any team member as per CARPA guidelines / CD Recall Schedules

Mark items due with / On completion mark with \

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#### GENERAL

Routine clinical items (BP, Weight, Waist, BMI, BGL, UA)

- Feet
- PEF/Spirometry
- Urine ACR
- Skin
- Teeth

#### BLOODS

- FBE
- LFT
- Lipids
- EUC+/- Cr C1
- BGL (fasting)
- HbA1c
- Renal Bloods
- Other

#### IMMUNISATIONS

- Flu

#### SPECIALIST SERVICES

- General Physician (GP)
- Dentist
- Cardiologist
- ECG
- Echocardiogram
- Renal Team
- Mental Health Team
- Other

See specialised plan/s for:

- RHD
- CLD
- Renal
- Warfarin
- Mental Health
- Other

### PART 4 Chronic Disease Care Plan Review

Review as per CARPA

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<th>BLOODS</th>
<th>URINE</th>
<th>FEET</th>
<th>OTHER</th>
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<td>kg</td>
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Comments / Brief Intervention:

Personal Goals – Progress made:

New plans /Goal:

Signature DMO/GP/AHW/RN

Date completed: Review GP Management Plan 725 Y/N

Review Team Care Arrangement 727 Y/N

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New plans /Goal:

Signature DMO/GP/AHW/RN

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Review Team Care Arrangement 727 Y/N

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Annual Chronic Disease Program Plan due:  

Two yearly HIC GP Management Plan or Team Care Arrangement due: 

Note GPMPs and TCAs can be done after one year if the patient’s condition warrants it. See MBS for details.