

Patient's Name:

I have explained the steps and costs involved, and the patient has agreed to proceed with the service. The patient also agrees to the involvement of other health providers and to share clinical information without / with restrictions (identify).....(GP's Signature & Date)

TEAM CARE ARRANGEMENTS

Goals - changes to be achieved.	Required treatments and services including patient actions.	Arrangements for treatments/services (when, who, contact details).

Copy of TCA offered to patient? YES / NO	Copy / relevant parts of the TCA supplied to other providers? YES / NO
TCA added to the patient's records? YES / NO	Referral forms for Medicare allied health and dental care services completed? YES / NO [For referral forms call 1800 067 307 or go to www.hic.gov.au/providers/forms]

Date service was completed: Review Date: