GP Management Plan/Team Care Arrangement (Item 721/723)

Patient Details	Doctor Preparing GPMP/TCA
Mr/Mrs Address: D.O.B: Medicare No.:	Dr Provider no.: Address: Phone: Fax:
Medical history	**Current Medications**

Details of Care Management Plan

Date Care plan completed: ***Date of review:***

Condition	Goals	Tasks/Actions	Provider
			☐ GP ☐ Ex Physiologist ☐ Dietitian ☐ Psychologist ☐ Physiotherapist ☐ Other
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Team Care Arrangement

Care Provider	Category of Care	Phone	Fax	Agree to participate	Signature
Vario Wellness Clinic	Exercise Physiology	6304 3444	6304 2499		
Vario Wellness Clinic	Dietetics	6304 3444	6304 2499		
Vario Wellness Clinic	Psychology	6304 3444	6304 2499		
Vario Wellness Clinic	Clinical Psychology	6304 3444	6304 2499		
Vario Wellness Clinic	Physiotherapy	6304 3444	6304 2499		

Patient Agreement/Consent

I of hereby agree to the development of this Care Plan. I understand that this information may be shared with other allied health care providers involved in the management of my medical care. I am aware that this Management Plan will be billed to Medicare in my name.

Signed by patient: Date:

Signed by GP: Date: