LinkMyCare - Chronic Obstructive Pulmonary Disease Care Pathway

Enrolment form

The LinkMyCare – Chronic Obstructive Pulmonary Disease (COPD) Program aims to improve coordination of, and increase access to, care for people living with Chronic Obstructive Pulmonary Disease in the Illawarra Shoalhaven Local Health District (ISLHD) and the Southern NSW Local Health District (SNSWLHD).

This program is a partnership between three organisations: Illawarra Shoalhaven Local Health District, Southern NSW Local Health District, and COORDINARE - South Eastern NSW PHN.

Learn more here.

PATIENT DETAILS			
Patient's name:			
Date of birth:		Identifies as:	
Street address:		Phone number:	
		Email:	
Medicare card number:		Medicare card reference number:	
Medicare card expiry date:			
Does the patient identify as (please tick):			
☐ Aboriginal ☐ Torres Strait Islander		☐ Both Aboriginal and Torres Strait Islander ☐ Neither Aboriginal or Torres Strait Islander	
Country of birth:		Preferred language:	
Patient's usual General Practitioner:		Patient's usual GP Practice or ACCHS:	

DETAILS OF HEALTH PROFESSIONAL COMPLETING THIS FORM	
Health professional's name:	
Name of GP practice, AMS/ACCHO, or LHD:	
Address:	
Phone number:	
Email:	

I CONFIRM THAT	Agree	No
I have discussed the LINKMYCARE - CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD) PROGRAM and provided the LinkMyCare - COPD Patient Participant Information Sheet to the patient, and the patient has provided consent to be enrolled in the program and for use/disclosure of their personal information. OR	☐	☐
I have discussed the LINKMYCARE - CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD) PROGRAM and provided the LinkMyCare - COPD Patient Participant Information Sheet to the patient/authorised representative, and the authorised representative has provided consent for the patient to be enrolled in the program and for use/disclosure of their personal information. Authorised Representative Name: _____Phone: _____	☐	☐
The patient/authorised representative is willing to be contacted by the Program team for feedback (e.g. via a survey) on their personal experience of the LinkMyCare - Chronic Obstructive Pulmonary Disease (COPD) Program.	☐	☐
The carer (if applicable) is willing to be contacted by the Program team for feedback (e.g. via a survey) on their personal experience of the LinkMyCare - Chronic Obstructive Pulmonary Disease (COPD) Program. Carer Name: _____ Relationship to Patient:_____ Phone:_____	☐	☐
Date:		

In addition to the COPD Patient Participant Information Sheet, please provide a copy of the My COPD Annual Cycle of Care document to the patient.