Management Plan with Team Care Arrangements for patients with multidisciplinary care needs. To be conducted by the patient's usual GP

	GP prepares	GP Review	GP contributes
General Practice Management Plan	721	732	729
Team Care Arrangements	723	732	729
Aged Care Resident Care Plan			731

GP Management Plans (GPMP) and Team Care Arrangements (TCA) are a part of the Commonwealth Governments 2005 Enhanced Primary Care Package. Together they allow the use of the allied health and dental item numbers for approved providers. As a member of the care team I am forwarding a copy of the Management Plan and Team Care arrangements for your records. Could you please review these documents and write back with any comments on this plan and I will incorporate the changes into a new GPMP and TCA. If the plan is satisfactory please fax the plan back to our fax number below with your approval. Our practice's fax policies ensure patient privacy. I will review and update this plan at regular intervals and let you know of any changes in the plan. Please contact me if you have any questions about this patient or their care.

PATIENT DETAILS

Patient's Name: Mr Donald Duck
Date of Birth: 10 Sep 1900
Address:
20 Burnt Street
Nunawading
3131
VIC
Email: dduck@mail.com
Mobile:
Phone: 9896290355
Medicare Card No: 3416 00000 2
Healthcare Card No: 223344565789

Contact details of carer if appropriate
Name:
Relationship:
Contact Details

MEDICAL PRACTITIONER DETAILS

Name: System Administrator
Provider No:
Email:
Phone: 02 9690 8666
Address:
Lisa's Surgery
Level 1 83 Palmerston Crescent
Darlinghurst
NSW
2010

MANAGEMENT PLAN HISTORY AND OTHER CHECKS

Home medication review within the last 12 months
Yes ☐ No☐

Health assessment within the last 12 months
Yes ☐ No ☐

GP Management Plan within last 2y
Yes ☐ No ☐

Team Care Arrangements Service within last 2y
Yes ☐ No ☐

EPC referral to allied health providers
Yes ☐ No ☐

Verbal consent to GP Management Plan and Team Care Arrangements and to provide a copy to relevant providers of care
Yes ☐ No ☐

Advanced health directive has been discussed
Yes ☐ No ☐

"My Health Record" has been prepared Yes ☐ No ☐

This GPMP & TCA if required will be available in "My Health Record"
Yes ☐ No ☐

If the patient eligible under Veterans Affairs. Please ensure thi s form is available on request from DVA

PROBLEM LIST Include medication list if appropriate as of

Medical Summary:

Asthma - Patient is allergic to smoke and dust

Comment:

Medication List:

Salbutamol sulfate 100 mcg/1 dose 200 doses (Airomir Autohaler Inhaler) Use theree times a week

Comment:

Allergies and Intolerances:

20 Aug 2010 - Alcohol
09 Mar 2011 - Allergen extracts - Patient is allergic to dust and pollen

Comment:

Vaccinations:

Comment:

Patient consents to release of clinical details Yes ☐ No ☐

MANAGEMENT PLAN GOALS and TEAM CARE ARRANGEMENTS IF REQUIRED

General Practice Management Plan

Consider3 monthly FBC MBA with copy to renal physician-

Consider annual fasting Chol TG HDL-

Consider annual CK on a statin-

Urinalysis annually-

Consider serum and urine iEPG-

Calculated creatinine clearance-15 Nov 2010
MG/DL :8

iPTH and Iron studies each 6 months with copy to renal physician-
Regular skin check recommended Yes ☐ No ☐

Faecal occult blood test every 2 years recommended from 50-
Regular Colonoscopy screening recommended Yes ☐ No ☐

Pap Smear each 2 years to 18-70-
Mammogram each 2 years from 50 -70 (consider annually from 40 with a family history of breast cancer)-

Regular PSA and rectal examination screening scheduled Yes ☐ No ☐

Inform of risks, uncertainties and benefits of annual PSA and rectal examination from 50-70 (From 40 with family history of prostate cancer < 60). Routine screening currently not recommended by RACGP or NHMRC.

Team Care Arrangements and frequency of review

General Practitioner each month-
General Practitioner each 3 months-
General Practitioner each 6 months-
General Practice Nurse each 12 months-

Pharmacist review monthly

Specific goals

Home blood glucose monitoring Yes ☐ No ☐

Home blood glucose monitoring targets between 4-8 mmol/l
Frequency of home glucose monitoring-
On Insulin-
Moniter for increased insulin sensitivity with decreasing renal function-
Injection technique review required- Yes ☐ No ☐

Has hypokit at home Yes ☐ No ☐

Twice yearly diabetes review, HbA1c target less than 7 %-

Most recent HbA1c -
Microalbumin raised -
Annual Microalbumin assessment required-
Target Hb of 11-12-
Patients with iron saturation below 20-30% or ferritin below 200-300 should be considered for iron supplements as Iron infusion if indicated-
Erythropoietin should generally be administered weekly subcutaneously to pre-dialysis patients who have anemia-dependent angina or severe anemia with a hemoglobin concentration below 100 g per dL)-
Serum bicarb above 20mmol/L with Sodium bicarbonate tablets used (caution should be used due to its significant salt load and fluid retention)-

Annual Cholesterol with targets below 4.0 mmol/l-

HMG CoA reductase inhibitors may retard the progression of renal failure-
Current Cholesterol -H - High
Value :5
mmol/l 17 Mar 2011
Phosphate should be maintained in the normal range. Parathyroid hormone levels begin to rise when creatinine clearance falls below 60 mL per minute. The development of hyperparathyroidism may be prevented by restricting dietary phosphate, using a calcium-based phosphate binder with meals or Renagel (Sevelemar) and administering vitamin D (Rocaltrol) to suppress parathyroid hormone secretion.

Promote understanding and appropriate use of medications- Patient held updated medication list- Home medicine review recommended Yes ☐ No ☐ Dietitian review for modification of diet to consider low phosphate (but protein restriction should not be less than 0.8-1 mg/kg/day, low potassium, high calcium diet while maintaining nutritional needs- Diabetes education with the diabetic clinic- Diabetes diet requirements in a group setting- Consider Annual Ophthalmologist review for falls prevention, glaucoma screening and complication screening- Consider specialist review for screening and management of complications- Consider Dental review for screening and management of complications- Consider Psychologist review for supportive psychotherapy and cognitive behavioural therapy- Consider Podiatrist review for nail care as required with annual complications screening- Peripheral neuropathy present Consider Physiotherapist review for active physical therapy and rehabilitation- Consider Exercise Physiologist for a motivational interview, to assist in developing a structured exercise program and to monitor progress- Consider Occupational Therapist home visit for falls prevention- Consider Community care package for assistance with meals, housework, shopping, transport, financial organisation and medication supervision-	Calcium should be kept around 2.5 mmol/L. Phosphate should be kept below 1.5 mmol/L. Even with appropriate medical therapy, some patients continue to have refractory hyperparathyroidism because of parathyroid gland hyperplasia. These patients should be referred for surgical treatment Target weight loss for the next 12 months of << >> Current blood pressure-Systolic :130 Diastolic :80 21 Aug 2010 Cholesterol from 45 with targets below 4.0 mmol/l Current Cholesterol-H - High Value :5 mmol/l 17 Mar 2011 Target fasting BSL <5.5 Current fasting BSL- Urinalysis normal- Yes ☐ No ☐ Consider Vaccination to prevent Influenza and Pneumococcal disease- Consider Antiplatelet agents in patients with , or at high risk, of Coronary artery disease (CAD)- Consider ACE inhibitors in patients with CAD or CCF- Consider Beta-blockers in patients with CAD or CCF- Consider Statins in patients with, or at high risk, of CAD- Consider Sodium bicarbonate tablets 1-4 tablets per day to maintain serum bicarb above 20mmol/L- Consider Calcium supplements or Renagel to maintain phosphate in the normal range- Consider Calcitriol to maintain serum calcium in the normal range- Use of Metformin contraindicated by renal disease (GFR<30)- **Avoid** Avoid NSAIDS Avoid medication known to reduce kidney function Avoid the use of forearm veins in the non dominant arm for blood tests, drips or even blood pressure measurement to preserve them for possible future arteriovenous fistulas required for haemodialysis **Action Plans** Exacerbation management plans eg. Frusemide dose adjustments with weight gain and diabetic medication dose adjustments with illness along with increased frequency of testing In an emergency dial 000 for ambulance **Healthy lifestyle** Smoker Yes ☐ No ☐ Complete cessation of smoking and avoidance of passive smoking. Quiteline 131848. Consider pharmacotherapy if smoking more than 10 per day. Establishment and maintenance of healthy eating with saturated and trans fatty intake < 8% of total energy Heartline 1300362787 or www.heartfoundation.com.au Low risk alcohol consumption for those who drink. Alcohol consumption restricted to a maximum of 4 standard drinks, usually alcohol confined to 1-2 standard drinks per night and abstain from alcohol for 2 nights per week. Moderate regular exercise whose medical condition is clinically stable. Goal of 30-60 minutes per day brisk walking. **Health of caregiver** Carers are at risk of depression, anxiety emotional distress loneliness and isolation. Carer support may be achieved through support groups, respite care,

	for carer support resources contact Carelink 1800 052222 www.commcarelink.health.gov.au **Patient support organisations** Diabetes Australia supports people who have been diagnosed with diabetes and their families Web site: www.diabetesaustralia.com.au/home/index.htm Kidney Health Australia supports people who have been diagnosed with kidney disease and their families Web site: www.kidney.org.au

PATIENTS AGREEMENT

I agree with the goals of this care plan and I understand the recommendations

_____Signed by patient Date

Mr Donald Duck

_____Signed by GP

System Administrator

General Practice Management Plan or Team Care Arrangements each 2 years. Review after 6 months
New General Practice Management Plan or Team Care Arrangements after 12 months if clinical conditions change markedly.
Review General Practice Management Plan or Team Care Arrangements after 3 months if clinical conditions change markedly.
To be given to the patient and other team members as appropriate.
All participants undertake to retain confidentiality