



New England Division of General Practice

Chronic Disease Team Care Arrangement (TCA)

(To claim Item 723, all sections must be completed)

Patient Details

Today's Date:/...../.....

Name: _____ GP _____

Address: _____

DOB:/...../..... SEX: M F Aboriginal/Torres Strait Islander Yes No

Dept. Veteran Affairs? Yes No

1 DIAGNOSIS

Approx date, if relevant / /

- | | |
|--|---|
| <input type="checkbox"/> Acute MI _____ | <input type="checkbox"/> Coronary Angiogram _____ |
| <input type="checkbox"/> Angina/IHD _____ | <input type="checkbox"/> Cardiac Echo _____ |
| <input type="checkbox"/> CAGS _____ | <input type="checkbox"/> Stress Test + / - _____ |
| <input type="checkbox"/> Angioplasty/Stent _____ | <input type="checkbox"/> Thrombolysis _____ |
| <input type="checkbox"/> CCF _____ | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Peripheral Vascular Disease _____ | |
| <input type="checkbox"/> Cerebral Vascular Disease _____ | |
| <input type="checkbox"/> Cardiomyopathy _____ | |

2 RISK FACTOR IDENTIFICATION

- Family History
- Hypertension Current BP _____ **Target: < 130/85**
- Diabetes Mellitus HbA1c _____ **Target: < 7**
- Lipids
Current Chol _____ mmol/L Trig _____ mmol/L HDL _____ mmol/L LDL _____ mmol/L
**Targets for IHD: Total cholesterol < 4.0 Trig < 2 mmol/L
HDL > 1.0 mmol/L LDL < 2.5mmol/L**
- Lipid lowering Medications Yes No

- Smoking: Never Past Current
(3 months or more)

- Physical Inactivity **Target: 30 minutes x 5 days per week**

- Weight Weight _____ kg
Height _____ m
BMI _____ kg/m² **Target: BMI 20-25kg/m²**
Waist circumference _____ cm **Target: Male ≤ 94 Female ≤ 80**

- Psychosocial _____

(over)



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3 MEDICATION (Tick)

- | | |
|--|--|
| <input type="checkbox"/> Aspirin/ Antithrombotic | <input type="checkbox"/> Anticoagulant |
| <input type="checkbox"/> β -blocker | <input type="checkbox"/> Hypoglycaemic Agent |
| <input type="checkbox"/> ACE Inhibitor/ A2 Rec. Antagonist | <input type="checkbox"/> Nitrates |
| <input type="checkbox"/> Ca- Antagonist Channel Block | <input type="checkbox"/> Diuretics |
| <input type="checkbox"/> Statin/ Lipid Lowering Agent | <input type="checkbox"/> Other _____ |

Home Medicines Review (HMR – MBS item 900) Yes No

4 HEALTH PROVIDERS/SERVICE

Current (eg GP, Cardiologist/physician/Cardiac Rehabilitation Program (CRP) _____

Others likely to assist (eg CRP team, Dietitian, OT, Community Health Nurse) _____

5 REFERRALS TO

- Cardiologist _____
- Dietitian _____
- Physician _____
- Physiotherapist _____
- Social Worker _____
- Occupational Therapist _____
- Diabetes Educator/Program _____
- Community Health Nurse _____
- Psychiatrist/psychologist _____
- Pharmacist (Home Medicine Review) _____
- Other _____

TEAM CARE ACTION/RECOMMENDATIONS	Provider	Review Date
1.		
2.		
3.		
4.		
5.		

Copy to _____ (TCA Report will be sent to all referees nominated above)

Authority to proceed with Team Care Arrangements

GP signature _____ Patient signature _____ Date _____

Please fax or send to: Heart Health Program Manager, New England Division of General Practice,
PO Box 1321 Armidale NSW 2350 Ph: 02 6771 1146 Fax: 02 6771 1170