



# Coordinated Veterans' Care Program Community Nursing GP Feedback

## Contact Information

### Gold Card Holder:

1: DVA File Number

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2: Date of Birth

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3: Title  Mr  Mrs  Miss  Ms  Other

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4: Full name

### Community Nurse Details:

5: Provider Organisation

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6: Community Nurse full name

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7: Contact numbers  
Telephone number  Fax

### GP Details:

8: GP full name

### Nursing Treatment/Care Plan

Please use additional space on page 3 or a separate sheet if information does not fit in the space provided.

Please list personal actions and goals agreed to by entitled person. Please list support and clinical nature of Community Nurse Care Coordination as per Attachment E of the DVA Guidelines for the provision of community nursing services.

	Entitled Person		Community Nurse Activities	
	Actions	Goal(s)	Support	Clinical
<p>9: Psychosocial Support <input type="checkbox"/> No <input type="checkbox"/> Yes</p>				
<p>10: Chronic Disease <input type="checkbox"/> No · Education <input type="checkbox"/> Yes · Support <input type="checkbox"/> · Coaching <input type="checkbox"/></p>				
<p>11: Vital signs/ Observations with reportable levels and results <input type="checkbox"/> No <input type="checkbox"/> Yes</p>				

**12: Blood glucose monitoring and results**  No  
 Yes

**16: Pain Monitoring**  No  
 Yes

**13: Medication Monitoring**  No  
 Yes

Entitled Person		Community Nurse Activities	
Actions	Goal(s)	Support	Clinical

**13b: Do you require an additional Medication list from the GP?**  No  Yes

**17: Liaison with other health care professionals**  No  
 Yes

**18: Intervention/s**  No  
 Yes

Health Professional	Outcome
Interventions	Outcome

**15: Carer Support**  No  
 Yes

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**19: Review and Renewal Periods**

Next 28 day review date:

Next Quarterly review date:

Next annual GPMP reevaluation date:

**20: Were there any Clinical Care changes in this period?**

No - continue to next page  
 Yes - complete below ▼

Clinical Care changes: Period Start Period Start

Reason for change (e.g. palliative care, admission to hospital etc)

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**21: Additional Information**

Question Number

Question Number

Question Number

Question Number

Question Number

Question Number

Entitled Person		Community Nurse Activities	
Actions	Goal(s)	Support	Clinical

**21: Additional Feedback for GP**

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**Signature**

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Printed name:
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