

GP Guide to the Healthy@Home Chronic Disease Service

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You refer your patient to the Healthy@Home Chronic Disease Service.



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Within a maximum of 4 weeks your patient will be offered an initial appointment with a Clinical Nurse Specialist and a follow-up appointment to discuss their health issues and prepare a plan of care.



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You will receive a copy of your patient's agreed plan of care.



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Following the assessment and care planning interviews, your patient will be offered a self-management program, lifestyle group education, and/or exercise programs.



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After your patient completes the program, you will receive a copy of their ongoing self-management plan which includes links to community activities and services to support their plan of care.