CLIENT EXPERIENCES

'People should take the program up and listen to the advice and follow it through because it's the best thing you can do. You got to get off what is making you worse. You got to give it six months. I didn't realise how sick I was getting over a long time. Keep going and get the reward of it down the track. Now at 69 years of age I am jogging again.'

- Rodney from Ashmore manages his Heart Failure

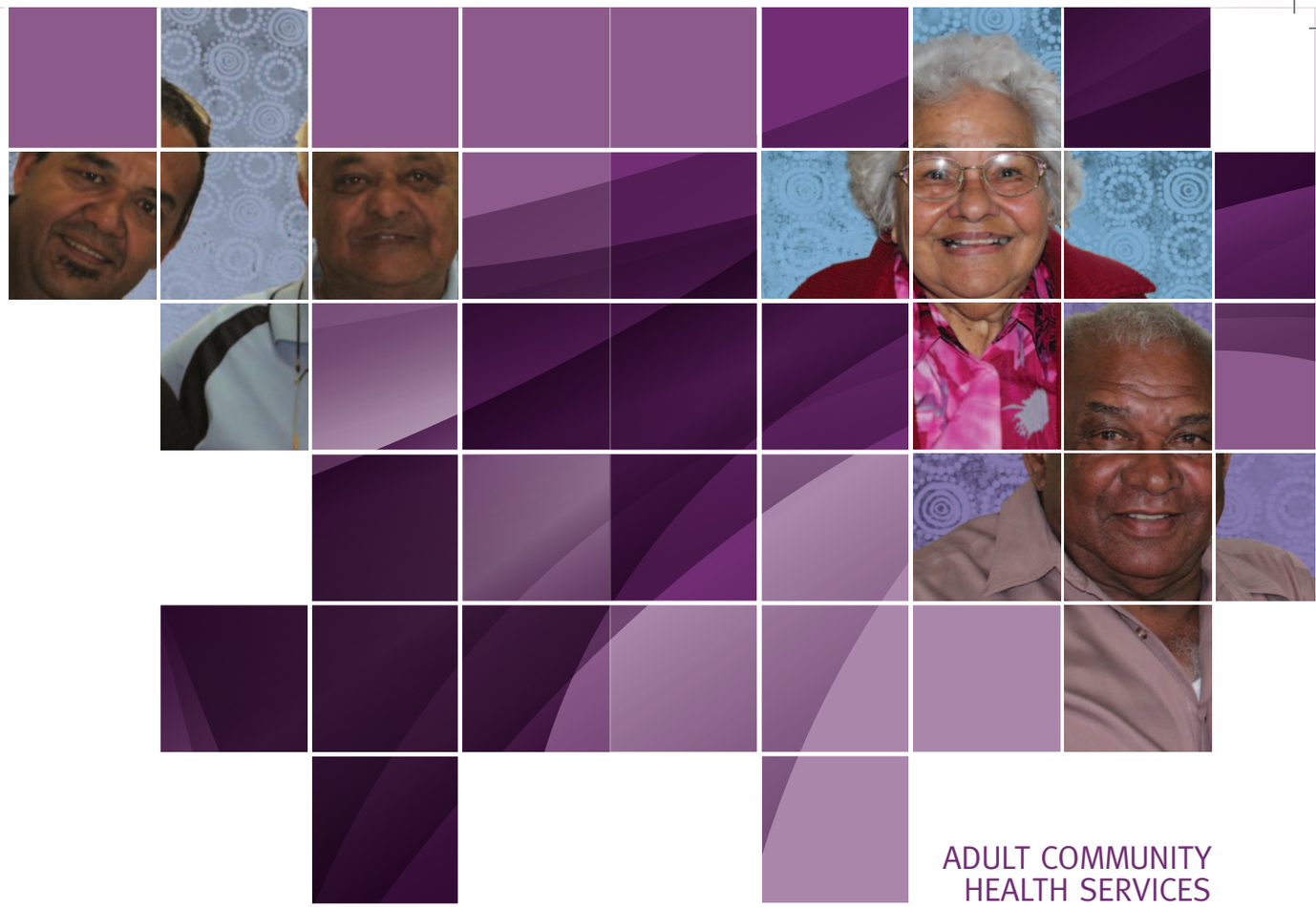
I have learned how important it is to have a good management plan with your GP. It is equally important to have a comprehensive understanding of the medications we use. I also learned how to deal with family relationships, which can become quite strained when a chronic illness is present. Coping strategies were also invaluable in helping me to cope with daily living. I also benefited from Respiratory Rehab programmes, with the added bonus of losing weight.

- Yvonne, Helensvale

GOOD TO KNOW

If you are seen by a Specialist Medical Doctor, you may be bulk-billed for your appointment. This will require your signing a payment slip.

Please be aware that this brochure may contain images of deceased people. Queensland Health strives to treat Indigenous culture and beliefs with respect. We acknowledge that to some communities, it is distressing and offensive to show images of people who have died.



ADULT COMMUNITY HEALTH SERVICES

ENQUIRIES & APPOINTMENTS

To refer contact Central Intake Unit

Phone 1300 668 936
Fax 1300 668 536

GPs can access referral template on www.gpgc.com.au

Queensland Government

CHRONIC DISEASE WELLNESS PROGRAM

ADDING LIFE TO YEARS

Queensland Government

Gold Coast Health
Building a healthier community

CHRONIC DISEASE WELLNESS PROGRAM

WE CAN HELP WHEN YOU HAVE A DIAGNOSIS OF:

Chronic Obstructive Pulmonary Disease (COPD), Heart Failure, Type 2 Diabetes or Chronic Kidney Disease.

These conditions are known as Chronic Diseases. We offer services to assist you to manage these conditions so they have less impact on your day to day life.

We need to work with your GP during and after the program. Your GP will remain your primary carer. If you do not already have a GP, we will endeavour to help you find one.

Note: If you are unwell, you should consult your GP or in an emergency telephone an ambulance on ooo.

THE PROGRAM AIMS TO:

- Help you get the most out of life
- Reduce your risk of complications
- Support you to recognise when you need to go to hospital
- Help you stay well enough to keep you out of hospital

TO ACHIEVE THIS, WE WILL WORK TOGETHER AS PARTNERS. WE FOCUS ON:

- Understanding your condition
- Recognising changes in your symptoms and taking the appropriate course of action to solve them
- Making healthier choices
- Understanding what is available to assist you in your community
- Developing your confidence to work with your GP and health services as a partner

WHAT TO EXPECT:

Contact: We will contact you within 3 working days of the service receiving the referral.

You and your GP will be given the details of a contact person who will ensure your care is well coordinated. You may also choose to give this contact persons details to other services involved in your care.

Screening: We will have conversations with you to identify what we need to work on together.

Assessment: Specific assessments identified during screening will be completed by the appropriate health professionals.

A Care Plan: Together, we will make a plan to help you manage your condition. Your care plan will be kept by you and (with your consent) forwarded to your GP.

We expect that you will be with us for up to 12 weeks, depending on your condition. We will plan for what you need to have in place after the program.

Education: Group and/or individual education is available to help manage your care. At group education you will have the opportunity to meet others who have similar health experiences.

Exercise (after medical clearance): To suit your needs, we offer a range of exercise opportunities. We encourage you to discuss exercise ideas with your GP.

Learn about and try a suitable exercise activity available in your local area.

Clinic attendance: If it is identified in your care plan that you would benefit by seeing a range of health professionals, we may need you to attend a clinic.

Clinics may include a specialist doctor; however this is unlikely to occur if you are already seeing a private specialist.

Communication: Your GP will receive updates about your progress. Your GP can inform other specialists as required.

Case conferencing: Health professionals involved in your care will review your progress and discuss suggested changes with you

Support groups: Are available for some conditions. The program also links with Palliative and Supportive Care services where needed.

People with Chronic Disease often feel ‘down’ or anxious. We understand this and have staff who are skilled to help you.