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| **ATRIAL FIBRILLATION** | **1. Determine cause and treat appropriately 2. Restore heart to normal rhythm and reduce heart rate 3. Blood clot prevention 4. Manage risk factors for Stroke 5. Prevent additional heart rhythm problems 6. Prevent heart failure** | | | | | | | Pharmacological treatment Encourage healthy weight Encourage smoking cessation if required Encourage avoidance of alcohol and other drugs ECG annually and PRN Cardiologist review annually and PRN | **ECG done Echo: Cardiologist:** | | | | | |
| **Alcohol Use Disorder/ Dependence** | **Reduce risk of alcohol related harm over a lifetime by having no more than 2 standard drinks per day Reduce the risk of injury while drinking by drinking no more than 4 standard drinks on one occasion Aim to have alcohol free days or Abstinence from alcohol use** | | | | | | | Outpatient or residential detoxification and rehabilitation Counselling: individual or Group support such as Alcoholics Anonymous , SMART Recovery or other groups Referral to Addiction specialist | Alcohol and Drug Foundation (list of services) https://adf.org.au/help-support/support-services-directory/ | | | | | |
| **Alcohol Excess (Drinking exceeds recommended levels)** | **Reduce risk of alcohol related harm over a lifetime by having no more than 2 standard drinks per day Reduce the risk of injury while drinking by drinking no more than 4 standard drinks on one occasion Aim to have alcohol free days** | | | | | | | Brief intervention and motivational interviewing 3-6 monthly reassessment with AUDIT-C Additional services can be accessed by patient depending on level of assistance sought by patient (as listed in additional comments) | Alcohol and drug information service NSW https://yourroom.health.nsw.gov.au/Pages/home.aspx Youth Drugs and Alcohol Advice http://yodaa.org.au/workers/contact-us Alcohol and Drug Foundation (list of services) https://adf.org.au/help-support/support-services-directory/ | | | | | |
| **ASTHMA** | **1. Maintain resp function and reduce risk of acute exacerbation** | | | | | | | Preventative inhaler as prescribed Salbutamol inhaler as prescribed Ensure patient has correct inhaler technique Regular review and assessment | **Last spirometry done:** | | | | | |
| **PROSTATOMEGALY/BPH** | **Reduce BPH symptoms Monitor BPH symptoms** | | | | | | | Medication if required Monitor symptoms | **Routine review with GP** | | | | | |
| **CANCER SCREENING:** see RACGP www.racgp.org.au/guidelines/redbook <http://www.racgp.org.au/guidelines/redbook> | | | | | | | | | | | | |
| Cervical (female) | | Early detection | | | | PAP every year **Due:** | | | | | GP / Nurse | | | |
| Breast (female) | | Early detection | | | | Mammogram every 2 years (age 50 - 69) **Due:** | | | | | GP / Nurse/ BreastScreen | | | |
| Colon | | Early detection | | | | FOBT (every 2 years age 50 - 75) or colonoscopy (every 5 years if +ve Fhx) **Due:** | | | | | GP / Nurse | | | |
| **CHRONIC PAIN** | | **1. Manage pain** | | | | Pain clinic Pain medication Physiotherapy | | | | |  | | | |
| **CKD Stage** | | **1. Maintain renal function 2. Prevent further deterioration of renal function and associated complications** | | | | Investigations to determine underlying cause Assessment of absolute CV risk Optimal diabetes Mx, (where indicated) Avoid nephrotoxic medications or volume depletion Adjust medication doses to levels of appropriate renal function Referral to nephrologist as needed | | | | |  | | | |
| **COELIAC DISEASE** | | To reduce inflammation of bowel, prevent symptoms of same To provide ongoing education re coeliac disease and its treatment | | | | Gluten free diet - attend appt with dietitian Optimal diabetes management if has diabetes | | | | |  | | | |
| **COPD** | | **1. To maintain resp function aiming to continue normal ADL and maintain QOL 2. Reduce acute exacerbations** | | | | Regular PA as tolerated Quit smoking Consider pulmonary rehab Medications as indicated based on symptoms and severity (inhalers, steroids and mucolytics) Regularly check inhaler device technique and usage Spirometry at least yearly Detect, monitor and manage comorbidities in conjunction with COPD Refer to the Lung Foundation to access support groups and educational resources | | | | | **Spirometry done:** Lung Foundation Australia Level 2, 11 Finchley Street Milton, QLD 4064 Australia T: 1800 654 301 W: www.lungfoundation.com.au | | | |
| **CVD** | | **1. Reduce BP and minimise further cardiovascular complications** *Aim:*  < /= 140/90 mmHg or < /= 130/80 mmHg in those with albuminuria (urine ACR> 3.5mg/mmol in females and > 2.5mg/mmol in males) **2. Optimal lipid levels** *Aim:* TC: < 4.0 mmol/L HDL: ≥ 1.0 mmol/L LDL: < 2.0 mmol/L Non HDL < 2.5 mmol/L TG < 2.0 mmol/L  **3. Reduction in alcohol use 4.Smoking Cessation** | | | | Pharmacological treatment BP monitoring at every appointment Cardiologist review 6 monthly and PRN ECG and Echo 6 monthly and PRN Cardiac Rehab referral if required Chest pain action plan Pathology tests as needed Education about diet, lifestyle changes and weight management Dietitian referral if required Encourage avoidance of alcohol and other drugs Encourage smoking cessation Psychologist/Counselling referral if required | | | | | **ECG: Echo: Due: Cardiologist: next due:** | | | |
| **DEPRESSION** | | **1. Determine and treat cause where possible 2. Manage symptoms 3. Maintain QOL** | | | | Regular review and assessment Referral to mental health care team if required GP Mental Health Care Plan Medication as required Regular PA and healthy eating as per below | | | | | Mental Health Line: 1800 011 511 24hrs/7 days Partners in Recovery P: 1800 501 858 www.iwspir.com.au www.beyondblue.org.au P: 1300224636 www.blackdoginstitute.org.au | | | |
| **DIABETES** | | **1. Education** - patient to have ongoing education and understanding of their diabetes and own role in self-management, aiming to achieve goals of diabetes care, maintain QOL and minimise the burden of diabetes management and care **2. Stabilise daily blood glucose levels**  *Aim:*  6-8mmol/L fasting 6-10 mmol/L 2 hrs post meal  **3. Prevent chronic complications**  *Aim:* HbA1c target: <7% (53mmol/mol) ACR: < 2.5mg/mmol <3.5mg/mmol BP: < 130/80 mmHg Lipids: TC < 4.0 HDL > 1.0 LDL < 2.0 Trigs < 2.0 | | | | Ongoing education re self-management, ( BG monitoring acute complications etc) with GP, CDE, AHW, AHPs SMBG - x per day / week Take medication as prescribed, health care team to assess for adverse side effects Follow Australian guidelines for healthy eating and physical activity Diabetes clinic appt minimum 3 monthly: HbA1c 3 monthly ACR yearly or 3 monthly if CKD BP each visit Lipid profile yearly, more often if required Optometrist yearly (minimum) to include dilated fundal examination yearly Podiatrist yearly (minimum) Patient to do daily self-foot checks Dentist yearly (minimum) Medication review yearly Ensure cycle of care completed annually | | | | | Diabetes NSW - www.diabetesnsw.com.au Customer Care Line - 1300 136 588 NDSS - www.ndss.com.au **See below for Team Care Arrangements**  HbA1c due: ACR due: eGFR due: Lipids due: **See below for Team Care Arrangements** | | | |
| **DIVERTICULAR DISEASE** | | **1. Treat and manage disease 2. Manage pain** | | | | Dietary advice Pain relief when there is flare up or inflammation | | | | |  | | | |
| **HIGH FALLS RISK** | | **1. Prevent falls by: - determining level of risk for fall - maintain strength and mobility** | | | | Falls Risk Assessment - yearly or as indicated http://www.nari.net.au/files/files/documents/frop-com-screen-dec09.pdf Physiotherapy as indicated Walking Aids as needed www.myagedcare.gov.au CES PHN Aboriginal CNC support: 158 Liverpool Rd, Ashfield 2131 P: 97990933 F: 90090690 | | | | | **Falls Risk Assessment** Done: Next due: **Bone Mineral Density assessment** Last done: Next due: **Walking Aid used:** | | | |
| **FATTY LIVER** | | **1. Ensure there has been exclusion of other causes of abnormal LFTs: - e.g. Hepatitis, medications 2. Improve LFTs 3. Prevent deterioration of liver function and complications, including fibrosis and cirrhosis** | | | | Avoid all liver toxins, including medications and alcohol Low fat, high fibre diet Regular PA Achieve and maintain healthy weight as per guidelines Regular review and assessment | | | | | **Liver U/S done: LFTs due: Hep B screening done: Hep C screening done:** | | | |
| **GORD** | | **To determine possible cause Reduce signs and symptoms by treating accordingly** | | | | Investigations as required to determine cause Medication as required Weight loss where indicated Regular review and assessment Referral to gastroenterologist as needed | | | | |  | | | |
| **GOUT** | | **1. Treat acute gout attack and prevent future attacks 2. Treat pain at time of acute episode 2.Prevent recurrent gout, advanced gout and kidney stones** | | | | Pharmacotherapy Education about reducing consumption of foods high in purines Education about reducing alcohol and drinks high in fructose Encourage lifestyle modifications such as exercise and weight loss | | | | |  | | | |
| **CHRONIC HEPATITIS B** | | **1. Determine phase of infection 2. Consider treatment if in immune clearance or immune escape phase of infection** | | | | Pathology 6-12 monthly Non-invasive liver imaging as required Pharmacological treatment if in appropriate phase Hepatologist/Gastroenterology 6-12 monthly review | | | | | **Pathology taken: Fibroscan last done** | | | |
| **HIV** | | **Suppress virus with medication Prevent progression to AIDS** | | | | Anti-viral medication as prescribed Regular review and assessment Blood precautions | | | | |  | | | |
| **HYPERTENSION** | | **1. Reduce BP and maintain within normal limits to prevent complications of hypertension including CKD** | | | | BP monitoring at home and GP Pharmacotherapy to maintain BP within normal limits Regular review with Nephrologist if necessary | | | | |  | | | |
| **HYPOTHYROIDISM** | | **Maintain normal thyroid hormone levels and minimise possible effects of low function** | | | | Medication as prescribed Regular TFTs | | | | | **RN/ GP Endocrinologist if necessary** | | | |
| **IHD** | | **1. Prevent any acute complication of IHD 2. Minimise any further deterioration of heart function 3.** | | | | Treat to target any underlying cause - BP, lipids, diabetes Referral to cardiologist Cease smoking - currently attending smoking cessation clinic Maintain healthy weight and regular PA | | | | | **Echo done: ECG done:** | | | |
| **IRON DEFICIENCY** | | **1. Determine cause and treat appropriately** | | | | Referral to appropriate specialist Patient to report any symptoms Monitor iron levels regularly Dietary advice for iron replacement Iron supplements as needed | | | | |  | | | |
| **LIFESTYLE:** see RACGP www.racgp.org.au/guidelines/redbook <http://www.racgp.org.au/guidelines/redbook> | | | | | | | | | | | | | | | |
| **Smoking:** current | | | Complete cessation | | | | Opportunistic | | | | | Patient / GP / Nurse | | |
| **Weight:** BMI Waist circumference | | | Target weight: Ideal weight: BMI ≤ 25, Waist <94 cm males, <80 cm females | | | | Review every 6 - 24 months | | | | | Patient /GP / Nurse / Dietician | | |
| **Nutrition** | | | Healthy diet | | | | Review every 6 - 24 months | | | | | Patient /GP / Nurse Dietician | | |
| **Physical activity** Current: | | | Target: Ideal: 30 minutes of moderate activity on most days | | | | Review every 2 years | | | | | Patient GP / Nurse Exercise Physiologist | | |
| **Alcohol intake** Current drinks / day | | | Target: drinks / day Ideal: max 2 daily | | | | Review every 2 years | | | | | Patient / GP / Nurse | | |
| **LYMPHOEDEMA** | | | **1. Prevent progression of condition, reduce oedema and maintain movement 2. Alleviation of associated symptoms, prevention of infection, improvement of function and QOL** | | | | Referral at Lymphoedema Clinic Education regarding condition Exercise Skin care Compression therapy Manual lymphatic drainage if required | | | | |  | | |
| **OSTEOARTHRITIS** | | | **1. Alleviate pain and discomfort**  **2. Maintain mobility**  **3. Maintain QOL** | | | | Pain relief as required Anti-inflammatory meds as required Hydrotherapy Physiotherapy Falls risk assessment if needed Regular assessment and review Referral to orthopaedic specialist if necessary | | | | | **See below for Team Care Arrangements** | | |
| **OBESITY** | | | **1. Determine factors contributing to obesity - e.g. lifestyle, PCOS 2. To reduce weight - initially by 5-10% then reassess 3. Minimise risk of obesity related complications** | | | | Education re healthy food choices: low fat, high fibre as per guidelines Reduce portion sizes Minimise take away food, soft drinks, alcohol Ensure adequate water intake Medication if needed Increase PA: aim for 30 mins day of moderate intensity. (medical clearance required prior to commencing any new PA) Regular review and assessment Referral to dietitian/endocrinologist as needed | | | | | **Dietitian phone service Diabetes NSW 1300 136 588 Goal weight:** | | |
| **OBSTRUCTIVE SLEEP APNOEA** | | | **1. Determine diagnosis and possible cause 2. To ensure adequate respiratory function when sleeping 3. Prevent associated complications of OSA** | | | | Attendance at sleep studies clinic to confirm diagnosis and need for CPAP machine CPAP to be used as recommended Regular review and assessment at respiratory clinic Weight loss if possible/Achieve and maintain healthy weight as per guidelines Regular PA Annual diabetes screening (if no known diabetes) Careful attention to diabetes Mx in the presence of OSA | | | | | **If no known diabetes: Screening done:** | | |
| **OSTEOPENIA** | | | **1. Prevent fractures 2. Prevent further bone loss** | | | | **Calcium, Vit D and weight bearing exercises** | | | | | **DEXA done Next due** | | |
| **OSTEOPOROSIS** | | | **To prevent bone fracture by improving bone mineral density To maintain mobility** | | | | Regular monitoring to ensure adequate Ca, Vit D levels Medications as required/prescribed Stop smoking Limit alcohol to no more than 2 standard drinks per day or less Maintain healthy weight and optimise PA/weight bearing exercise Falls prevention education | | | | |  | | |
| **CHRONIC PANCREATITIS** | **To alleviate pain Prevent or treat malabsorption** | | | | Lifestyle modifications Analgesia as prescribed by GP Refer to pain management team as necessary Dietitian referral as required | | | |
| **PERIPHERAL NEUROPATHY** | **1. Determine cause and treat appropriately 2. Minimise risk of infection and injury 3. Prevent further deterioration** | | | At least yearly assessment with Podiatrist/GP/Specialist Optimal Diabetes management Ongoing patient education regarding daily foot care and appropriate footwear Immediate medical attention for injury/infection | | | | | | **Nerve conduction studies if required** | | | |
| **POLYMYALGIA** | **1. Treatment to reduce inflammation 2. Manage symptoms 3. Maintain QOL 4. Prevent loss of function of joints** | | | Rheumatology review as required Pharmacotherapy Regular pathology as required | | | | | |  | | | |
| **PERIPHERAL VASCULAR DISEASE** | **1. Decrease the occurrence of cardiovascular events and prevent death 2. Reduce limb symptoms, improve exercise capacity, and improve quality of life 3. Prevent or lessen disability and progression to limb loss.** | | | Lifestyle modification - cease smoking - regular PA and healthy diet: low salt, low fat Pharmacotherapy as needed, may include anti platelet therapy, anti-hypertensives, statins Refer to vascular surgeon as required | | | | | |  | | | |
| **RETINOPATHY - Diabetic** | **To slow progression of retinopathy and maintain vision** | | | Optimise blood glucose and blood pressure management Regular review with ophthalmologist Medications if required | | | | | |  | | | |
| **SMOKER** | **1. Smoking cessation 2. Lung disease prevention** | | | Encourage smoking cessation Offer smoking cessation aids review at every visit with GP or health worker Annual flu vaccination Pneumovax | | | | | | **CXR - done: - next due: Spirometry - done: - next due:** | | | |
| **URINARY INCONTINENCE** | **1. Determine cause and treat appropriately 2. Provide support and improve QOL** | | | Investigations as required Education and support Physiotherapy/OT/Continence advisor as needed Medications as necessary Determine eligibility for CAPS or Enable | | | | | | www.incontinence.org.au National Continence Helpline 1800330066 www.bladderbowel.org.au Incontinence Assessment done: **CAPS submitted on:** **Enable submitted on:** | | | |

**VACCINATIONS:** see RACGP www.racgp.org.au/guidelines/redbook <http://www.racgp.org.au/guidelines/redbook>

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| <http://www.immunise.health.gov.au> | | | |
| Hepatitis A | Prevent | Vaccination x 2 if at risk | GP / Nurse **Due:** | |
| Hepatitis B | Prevent | Vaccination x 3 is HBsAb and HBsAg -ve | GP / Nurse **Due:** | |
| Influenza | Prevent | Annual vaccination | GP / Nurse **Due:** | |
| Pneumococcal | Prevent | Vaccination ( refer immunisation handbook for timing of doses) | GP / Nurse **Due:** | |
| Tetanus/pertussis | Prevent | Vaccination age 50 and 65 years (and 28 weeks in pregnancy) | GP / Nurse **Due:** | |
| **VIT D DEFICIENCY** | **1. Prevent metabolic bone disease and osteoporosis 2. Ensure adequate Vit D levels** *Aim:* > 60 in men & premenopausal women > 80 in post-menopausal women | Advice/education re optimal sunlight exposure Vit D supplement as required Dietary advice for calcium intake |  | |