

We aim to create holistic opportunities to empower people to enhance their health.

We are constantly striving to better our service, if you have any feedback please phone us on:  
(07) 4789 9165

or write to us at:  
Integrated Health Care Partnership  
IMB 92  
PO BOX 1596  
Thuringowa Central  
QLD 4817

**The Integrated Health Care Partnership works in conjunction with the Townsville General Practice Network**



**Queensland  
Government**

## **Integrated Health Care Partnership**

Monday – Friday  
8.00am – 4.30pm

- Office – 4789 9165
- Mobile – 0437 113 651
- Fax – 4789 9185

After Hours  
After Hours GP  
1300 552 252

Monday – Friday 6pm-10pm

Saturday 12 Noon – 10pm

Sundays and Public Holidays  
8am till 10pm

After 10pm still ring 1300 552 252 for advice.

- Emergency  
• Phone '000'

Integrated Health Care Partnership  
Townsville Health Service District  
PO Box 1596  
Thuringowa Central Qld 4817  
(07) 4789 9165

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## **Townsville Health Service District**

### **Integrated Health Care Partnership**

### **Chronic Disease Self Management Team**



**Queensland Government**

## Integrated Health Care Partnership Program (IHCP)

Our program assists you stay as healthy as possible by providing information on:

- Understanding your condition better
- Recognising early warning signs of disease exacerbation
- Knowing what action to take when warning signs start
- Knowing what services to access and when
- Learning how to best manage your own care with help from other health care professionals
- Managing your lifestyle to maximise your quality of life

Involvement with our team will run for approximately 6 months.

During this time we will work closely with your family/Carer, GP, and the GP Practice Nurse, to develop an ongoing health care plan to support you long after our involvement is complete.

We can also assist in organising additional services such as home nursing care, respite care, and access to community health programmes.

## Who is Involved

### Clinical Nurse Consultant -Team Leader

**Care Plan Co-ordinator** (Registered Nurse) provides information related to your chronic condition, how to monitor, recognise and manage signs of changing health, assist in developing your Care Plan.

**Occupational Therapist** helps maximise your safety and independence in performing daily activities.

**Dietitian** provides nutritional assessment and advice for individuals and their carer/partner.

**Physiotherapist** assesses and educates you on your shortness of breath, functional mobility or acute pain management.

**Exercise Physiologist** assesses physical exercise tolerance, develops and helps implement safe exercise programs.

**Administration Officer** provides information on the program, general enquiries and administration support for the health professionals.

## Involvement with the programme comes with a number of expectations

### The IHCP Team

- Provide current information in a manner the client/carers can understand
- Involve Client / Carer in decision making
- Respect the choices of the Client
- Advocate on behalf of the Client / Carer
- Keep appointments and will contact you if they are unable to visit when scheduled

### The Client/Carer

- Actively participate in all aspects of the programme and decision making
- Contribute to development of care plan and goals to work toward
- Be willing to see IHCP Allied Health to support improved health outcomes
- Contact IHCP / GP if health deteriorates
- Inform staff of changes in your medications / treatment
- Ensure your residence is safe for us to visit, eg restrained dogs
- Let us know if you are not able to make booked appointments by contacting us to cancel
- Inform us if you change your address or phone number