Privacy, dignity and confidentiality
As a client on the Transition Care Program you will be given information about the responsibilities of service providers in maintaining confidentiality of client information; potential use of personal information and how to access your personal health information when required. You will be asked to give your informed consent (recipient agreement) before services commence.

Carer support and education
The Transition Care Program offers education and support for carers, including:
• education and self management
• advocacy
• contact phone numbers for support, information and reassurance
• involvement in developing care plans.

Where can I get more information?
You can ask your treating doctor and/or hospital staff for information about the Transition Care Program.

Consumer feedback
The Transition Care Program is committed to providing quality services and your comments and suggestions, including complaints, are welcome as they provide an opportunity to improve our service.

Contact us
Transition Care Program
Townsville Hospital and Health Service
PO Box 670, Townsville QLD 4810

Phone: (07) 4433 4500
Fax: (07) 4433 4501
TSV-Transition_Care_Program@health.qld.gov.au
What is the Transition Care Program?

Transition Care provides eligible older people with a package of services that include therapy, nursing support and/or personal care that will help them regain as much independence as possible and assist in making long term care and support arrangements.

It is a goal-orientated, time limited service for people at the end of a hospital stay. You can only access transition care directly from hospital.

What services are provided?

People will be offered a package of services to meet their individual needs, which may include:

- Therapy eg. Physiotherapy, Occupational Therapy
- Nursing care such as the administration of medication and wound care
- Personal care such as showering and dressing
- Domestic assistance such as light housekeeping and laundry
- Assistance with shopping for groceries
- Assistance to access your GP and outpatient appointments
- Mobility equipment and continence aids.

The Transition Care Program can be delivered in your home or in a “live-in” setting.

What is the GP’s Role?

Your case manager, with your permission, will inform your General Practitioner (GP) of your acceptance into the Transition Care Program. Your GP will be invited to participate in the planning and reviewing of your care during the program.

How do I know if Transition Care is right for me?

You need to be an older person and:

- In hospital and nearing the end of your hospital stay
- Able to benefit from a program that will help you improve your recovery and restore your independence as much as possible
- Have been assessed by the Aged Care Assessment Team (ACAT) as being eligible,
- Wish to be part of the Transition Care Program

Planning for services

Transition Care services are planned in consultation with you, your carer and family. Services will be reviewed at regular intervals to ensure they continue to meet your needs. Any changes to the services provided will be discussed with you or your carer by your Case Manager.

Will there be a fee for Transition Care services?

It is expected you will contribute (17.5% of the single aged pension) to the cost of your care if you can afford to do so.

If you are unable to pay any fees you will not be excluded from the program. You are able to apply for a fee reduction or fee waiver. If you wish to apply for this, please let your hospital staff or your Transition Care Program know and they will be able to help you apply for a fee reduction or waiver.