

**Service Developments - Chronic Disease Management
Opt In Form**

I Dr _____ hereby confirm that I have read the contents of Circular NCO-04-2020 of 2020 pertaining to the Agreement reached between the Department of Health, the Health Service Executive and the Irish Medical Organisation of 2019.

I further confirm that;

1. I wish to provide the Chronic Disease Management Programme to eligible patients with one or more of the Conditions in accordance with the Model of Service as outlined in the Agreement of 2019 commencing in Phase 1 with eligible patients aged 75 years and over.

and

2. I accept that the obligations arising for me under the Chronic Disease Management Programme as set out in the Agreement form part of my GMS Contract(s) with the HSE pursuant to Clause 41 therein.

and

3. I consent to the HSE advising my GP Practice Manager Software Vendor (as indicated below) that I will be providing the Chronic Disease Management Programme.

Socrates **Helix Practice Manager** **HealthOne** **Complete GP**

**Please indicate which Practice Management System is in use in your practice by ticking the appropriate box.*

GMS Number:

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Medical Council Number

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Practice Name (where applicable) & Address:

Practice Eircode:

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Signed by the Contractor:

Date:

Printed Name:

General Practitioner Stamp
