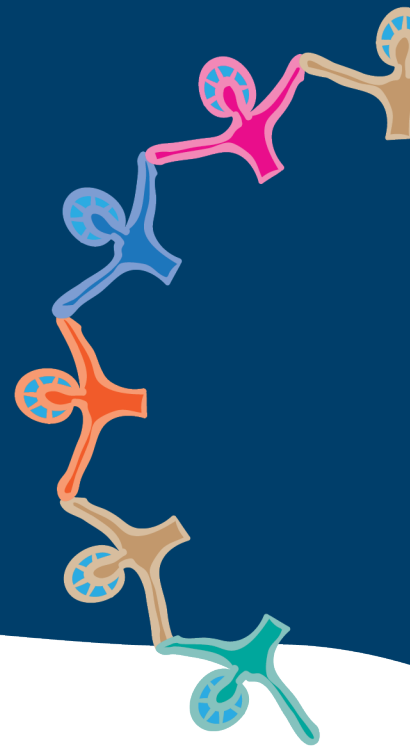


Welcome to general practice in northern Queensland

A guide for locum GPs, and anyone new to general practice in the region



NQPHN acknowledges the Aboriginal and Torres Strait Islander peoples as Australia's First Nation Peoples and the Traditional Custodians of this land. We respect their continued connection to land and sea, country, kin, and community. We also pay our respect to their Elders past, present, and emerging as the custodians of knowledge and lore.



ISO 9001
QUALITY



Contents

Acknowledgement of Country	4
Foreword: A message to locum GPs.....	5
Why this guide was created	6
About NQPHN.....	7
Our region.....	7
Who this guide is for	8
Locum GPs new to northern Queensland	8
Transitioning roles or context.....	8
What this guide covers – and what it doesn't	8
Communication, language, and colloquial speech.....	9
Communication style in northern Queensland general practice	9
Understanding colloquial language and slang.....	9
Strategies when you don't understand a patient	9
Working with interpreters and multilingual patients	10
HealthPathways and Smart Referrals	11
Navigating local care and referrals in northern Queensland.....	11
What is HealthPathways?.....	11
HealthPathways in the NQPHN region.....	11
Benefits of HealthPathways	11
How HealthPathways helps in everyday practice	11
What are Smart Referrals?.....	12
How HealthPathways and Smart Referrals work together	12
Practical tips for new general practitioners	12
Helpful mindset.....	12
Cultural capability and culturally safe practice	13
Cultural capability, cultural safety, and closing the gap.....	13
What cultural capability means when you're new to the region	13
The role of the team in cultural safety.....	13
Cultural capability in everyday clinical practice	14
Alignment with Closing the Gap.....	14
A lifelong professional skill.....	14
Supporting Integrated Team Care for Aboriginal and Torres Strait Islanders.....	15
Working in ITC.....	15



Cultural safety and team-based care	15
What cultural safety looks like in practice	15
Chronic conditions supported through ITC.....	15
Case studies (RACGP/ACRRM-aligned)	16
Regional practice case.....	16
Remote practice case	16
Key takeaways.....	16
Health assessments and MBS billing.....	17
Aboriginal and Torres Strait Islander health assessments.....	17
MBS Item 715 – Aboriginal and Torres Strait Islander Peoples Health Assessment .	17
Follow-up services.....	17
Non-indigenous health assessments (general population)	17
Common GP health assessment items.....	17
Key billing principles (quick reminders).....	17
Health Assessments and ITC.....	18
Key takeaways	18
Looking after yourself and thriving.....	19
Managing the transition	19
Wellbeing strategies	19
Staying connected	19
Where to seek help.....	19
You are never expected to manage.....	19
Words of wisdom from other locums and practice teams.....	20
Self-reflection	21
Practice-specific notes.....	21
Acronyms.....	22
References	23

Acknowledgement of Country

Northern Queensland Primary Health Network acknowledges the Aboriginal and Torres Strait Islander peoples as Australia's First Nation Peoples and the Traditional Custodians of this land.

We respect their continued cultural and spiritual connection to country, waters, kin, and community.

We also pay our respect to their Elders past, present, and emerging as the custodians of knowledge and lore.

We are committed to making a valued contribution to the wellbeing of all Aboriginal and Torres Strait Islander peoples of northern Queensland.

NQPHN's offices are proudly on Gimuy-Walubara, Yidinji, and Yirrganydji Country (Cairns), Bindal and Wulgurukaba Country (Townsville), and Yuwibara Country (Mackay).



For questions or practice support, contact NQPHN's Primary Care Engagement team at pce@nqphn.com.au or visit our website www.nqphn.com.au to access helpful resources and updates.

Foreword: A message to locum GPs

Welcome to general practice in northern Queensland – we're glad you're here.

If you're coming from another region (metro, regional, or rural), you'll already have strong general practitioner (GP) skills, but the day-to-day details can still feel different: local referral pathways, service availability, Queensland Health processes, and the practical realities of distance, weather, and community context.

Many locums describe the first few sessions as busy and cognitively heavy – not because the medicine is unfamiliar, but because you're learning new systems, new names, and new “how things work here” routines while keeping consultations safe and efficient.

This guide is designed as a practical orientation you can dip into between patients. It prioritises high-yield local information (referrals, escalation, cultural safety, and workflows) so you can settle quickly and work confidently from day one.

Think of this as a friendly, practical guide – not a rulebook. If you only read one part, **start with the Locum GP quick start** section at the front, then use the remaining sections as a reference when you need them.



Why this guide was created

This resource was informed by conversations with locum, rural, and regional GPs, educators, and practice teams across northern Queensland. Here are a few of the common themes that emerged:

- Referral pathways, service availability, and escalation processes vary by town and hospital and health service (HHS).
- Local digital tools (e.g., HealthPathways and Smart Referrals) are central to “how things work here.”
- Communication styles and expectations vary, and rapport-building often looks a little different to metro practice.
- Culturally safe care for Aboriginal and Torres Strait Islander peoples is a routine part of practice across the region.
- Geography, weather, and resource availability shape clinical decision-making, follow-up planning, and safety-netting.

This guide is designed to make your first few months clearer and better supported.



About NQPHN

Northern Queensland Primary Health Network (NQPHN) connects, funds, and supports primary healthcare services and providers so all northern Queenslanders can access the care and information they need to live healthier lives.

We do this through our core functions:

- **Commissioning** targeted services that respond to local health challenges and opportunities.
- **Capacity building** to strengthen the primary healthcare workforce and support innovation, data and quality improvement, business sustainability, and reform.
- **Coordinating** and connecting care across the system to improve access, as well as patient and provider experiences.

Partnerships are central to NQPHN's approach. We work collaboratively with Members, the health workforce, and health and community partners, to identify and address local needs and priorities. NQPHN is committed to strengthening these partnerships to achieve better health outcomes for northern Queensland communities.

Our strategic priorities are healthy communities, health equity, healthy system, healthy workforce, healthy intelligence, and healthy organisation, as defined in our [Strategic Plan 2025-28](#).

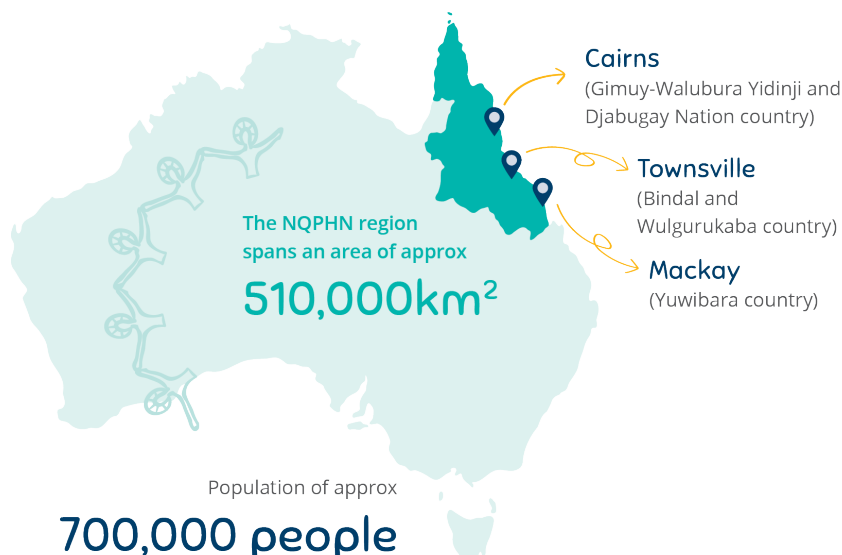
Our region

The NQPHN region is home to approximately 700,000 people, and extends from St Lawrence in the south coast, up to the Torres Strait in the north, and west to Croydon and Kowanyama.

We have over 90 staff operating across three offices in:

- **Cairns** (Gimuy-Walubura, Yidinji, and Djabugay Nation country)
- **Townsville** (Bindal and Wulgurukaba country)
- and **Mackay** (Yuwibara country).

NQPHN is one of 31 regional and independent PHNs established nationally by the Commonwealth Department of Health, Disability and Ageing.





Who this guide is for

Locum GPs new to northern Queensland

For general practitioners who are:

- providing locum services in northern Queensland for the first time.
- moving from another Australian region (metropolitan, regional, or rural) or internationally and learning local pathways.
- working short-term placements and needing a rapid, practical orientation.

Transitioning roles or context

Other primary healthcare professionals may also find this helpful for:

- transitioning from hospital-based work into community general practice
- new to rural/remote practice or outreach models
- returning to GP work after time away and wanting a refresher on local systems.

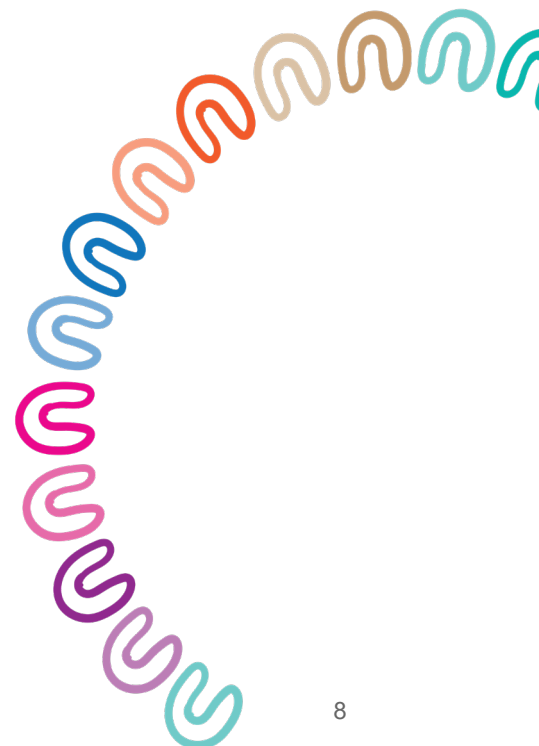
What this guide covers – and what it doesn't

This guide does aim to:

- introduce you to the northern Queensland GP environment
- introduce the NQPHN region
- explain everyday workflows
- support communication and cultural understanding
- provide practical scripts, scenarios, and tools.

This guide isn't designed to:

- replace RACGP/ACRRM training
- provide legal, visa, or employment advice
- offer detailed clinical guidelines
- give advanced billing interpretation.





Communication, language, and colloquial speech

Communication is one of the most important, and most challenging, parts of transitioning into general practice in northern Queensland. Even if you've worked elsewhere in Australia, this is often where you notice the biggest differences in consultation styles, expectations, and local language.

This section focuses on practical, everyday communication: how consultations tend to flow, patients describe symptoms, and building rapport while still managing time, boundaries, and expectations.

Communication style in northern Queensland general practice

In northern Queensland, communication in general practice is often:

- **informal but respectful.**
- **warm and conversational.**
- **patient-led**, with stories rather than short summaries.
- focused on **shared decision-making.**

Patients may use humour, minimise symptoms, or tell their story in detail. Taking a moment to listen before redirecting the consult can help build trust quickly.

A helpful mindset is to aim for:

Friendly, clear, and professional – rather than formal or distant.

Small gestures matter – greeting patients by name, brief small talk, and showing interest in their daily life or work often strengthen rapport.

Understanding colloquial language and slang

Patients in northern Queensland frequently use everyday language, slang, or regional expressions to describe symptoms. This can feel confusing at first, especially when words do not directly match to medical terms.

Rather than guessing, it is always appropriate to **clarify meaning**. Patients generally appreciate careful listening and follow-up questions.

Over time, you will naturally learn the patterns and rhythm of how people speak in your local community.

Strategies when you don't understand a patient

Not understanding something is normal – even for Australian-trained general practitioners. What matters is how you respond.

Helpful clarification phrases include:

- “Just to make sure I understand you correctly...”
- “Can you describe what that feels like for you?”
- “When you say ‘wobbly,’ what do you notice happening?”
- “Could you show me where it hurts?”

If a patient speaks very quickly, mumbles, or has a strong accent, it is appropriate to say: “Would you mind slowing down slightly so I don't miss anything important?”

Summarising back what you have heard (“Let me check I’ve got this right…”) also helps structure the consult and demonstrates active listening.

Working with interpreters and multilingual patients

Northern Queensland is a culturally and linguistically diverse region. Some patients speak English as a second or third language.

Professional interpreters should be used:

- if a patient requests one
- where a misunderstanding could affect safety or consent
- complex diagnoses or management plans are discussed.

Family members should not be used as interpreters for sensitive or clinical conversations.

When working with interpreters:

- speak directly to the patient
- use short, clear sentences
- pause regularly
- check the patient’s understanding at the end of the consult.

Cultural care reminder: Respectful care starts with listening, asking permission, and working at the person’s pace.





HealthPathways and Smart Referrals

Navigating local care and referrals in northern Queensland

Starting general practice in a new region can feel challenging – especially when referral processes, service availability, and local expectations differ from what you are used to. **HealthPathways** and **Smart Referrals** are two key digital tools designed to help you navigate **how things are done locally** and support safe, timely referrals.

What is HealthPathways?

HealthPathways is a web-based clinical and referral support tool designed to be used at the point of care by GPs and primary care clinicians. Each pathway provides locally agreed guidance on how to assess, manage and refer patients with a particular symptom or condition. Clinicians will need to register with each individual HealthPathways site to access the tool and its features.

HealthPathways in the NQPHN region

The Northern Queensland Primary Health Network region has three HealthPathways, designed to support each of our four regions.

- **Far North Queensland HealthPathways** (Torres and Cape and Cairns and Hinterland regions): <https://fnq.communityhealthpathways.org>
- **Townsville HealthPathways**: <https://townsville.communityhealthpathways.org>
- **Mackay HealthPathways**: <https://mackay.communityhealthpathways.org>

You can locate all local HealthPathways sites online at <https://communityhealthpathways.org/#AustraliaHealthPathways>

Benefits of HealthPathways

- Combine **clinical guidance** with **local referral information**.
- Reflect **local service availability, referral criteria, and processes**.
- Developed collaboratively by **local GPs, specialists, hospitals, and PHNs**.
- Help clinicians understand “**how things work here**.”¹

How HealthPathways helps in everyday practice


HealthPathways can support you to:

- decide **what can be safely managed in general practice**
- identify **when specialist referral is required**
- understand **local referral criteria** before submitting a referral
- find **patient information resources** to support shared decision-making
- reduce referral delays and rejected referrals.^{2 3}

¹ GPSA 2024

² GPRA 2026

³ RACGP 2025



Many clinicians new to the region find HealthPathways particularly helpful during their first weeks, as it provides clear, practical guidance aligned to the **local health system**, not just national guidelines.

What are Smart Referrals?

Smart Referrals is a **secure electronic referral system** used to send referrals directly from general practice software to **Queensland public hospitals and community services**. It is a Queensland Health initiative and is widely used across hospital and health services in northern Queensland.⁴

Smart Referrals:

- integrate with common GP software systems
- use **condition-specific referral templates**
- ensure required clinical information is included
- support faster triage and processing by hospital services.

How HealthPathways and Smart Referrals work together

HealthPathways and Smart Referrals are designed to be used **together**:

- **HealthPathways** helps you decide **whether** and **where** to refer, and what information is required.
- **Smart Referrals** is the tool used to **send** a referral electronically to the appropriate service.

Many HealthPathways include direct links or instructions for using Smart Referrals which are directed at the specific health condition or service.

Practical tips for new general practitioners

- **Use HealthPathways during the consult**, not just after.
- Check referral criteria **before** promising a referral to a patient.
- Ask your supervisor or practice manager which referral system your practice uses.
- If unsure, **document your reasoning** and seek advice early.

Helpful mindset

HealthPathways supports clinical decision-making – it does not replace your judgement. It is there to guide, not restrict, your care.

⁴ Queensland Health 2025



Cultural capability and culturally safe practice

Practising medicine in northern Queensland means working alongside Aboriginal and Torres Strait Islander peoples, communities, and cultures that are diverse, resilient, and deeply connected to Country. In the NQPHN region, cultural capability is not an optional skill but a core requirement of safe, effective, and professional general practice.

This section outlines key principles that support culturally safe care in northern Queensland, recognising that strong, respectful relationships, cultural humility, and ongoing reflective practice are essential to improving health outcomes and delivering care that genuinely aligns with Closing the Gap priorities.

Cultural capability, cultural safety, and closing the gap

Cultural capability is a core professional skill in general practice and is essential to delivering safe, high-quality care for Aboriginal and Torres Strait Islander people. Within the Integrated Team Care (ITC) model, cultural capability underpins how care is planned, delivered, and sustained over time. Cultural capability goes beyond awareness of culture. It involves ongoing self-reflection, learning, and adaptation, recognising that health is shaped by social, cultural, historical, and community contexts as well as clinical factors.

What cultural capability means when you're new to the region

For general practitioners working in ITC, cultural capability means:

- Practising with cultural humility, recognising that patients and communities are the experts in their own lives.
- Understanding the impact of colonisation, intergenerational trauma, racism, and inequity on health and engagement with services.
- Delivering care that is patient-led, relationship-based, and respectful of cultural identity and community connection.
- Recognising the importance of family, Country, community obligations, and lived experience when planning care.
- Cultural capability is not about having all the answers. It is about being open to learning, asking appropriate questions, and working respectfully alongside others.

The role of the team in cultural safety

ITC strengthens cultural safety by embedding care within a multidisciplinary team, particularly through the involvement of Aboriginal and Torres Strait Islander health workers and practitioners. These team members bring critical cultural knowledge, community connection, and trust that support patient engagement and continuity of care.

For general practitioners, this means:

- valuing Aboriginal health workers and practitioners as essential clinical and cultural partners
- seeking their input when planning care or addressing engagement challenges
- sharing decision-making and responsibility rather than working independently.

This team-based approach supports safer care for patients and a more sustainable model for clinicians.



Cultural capability in everyday clinical practice

In practice, culturally capable care may include:

- Taking time to build trust through consistent, respectful interactions.
- Using clear, plain language and checking understanding.
- Allowing space for patients to express their priorities and concerns.
- Respecting that patient goals may differ from purely biomedical goals.
- Being flexible with appointment structure, follow-up, and communication where possible.
- Reflecting on one's own assumptions and seeking guidance when unsure.

Cultural safety is determined by the patient's experience of care, not the clinician's intent.

Alignment with Closing the Gap

ITC aligns with Closing the Gap Priority Reforms, particularly those focused on:

- Improving access to culturally safe health services.
- Strengthening partnerships between communities and healthcare providers.
- Supporting coordinated care that reflects patient priorities and strengths.

For clinicians new to the region, developing cultural capability within ITC supports both professional standards and meaningful contribution to health equity.

A lifelong professional skill

Many general practitioners report that working within ITC:

- deepens their understanding of holistic, relationship-based care
- strengthens their cultural capability over time
- improves patient engagement and continuity
- enhances professional satisfaction and confidence.

Cultural capability is not a one-off competency – it is a lifelong professional responsibility, developed through reflection, relationships, and respectful practice.



Supporting Integrated Team Care for Aboriginal and Torres Strait Islanders

Working in ITC

Integrated Team Care (ITC) supports Aboriginal and Torres Strait Islander people with complex and chronic conditions to navigate the health system and access coordinated care.

As a general practitioner, you work within a team-based model that may include Aboriginal and Torres Strait Islander health workers and practitioners, care coordinators, allied health providers, specialists, hospitals, and community-controlled and mainstream services.

Your role includes providing continuity of clinical care, chronic disease management, care planning, prescribing, medication review, and referrals, while collaborating with the broader team to deliver holistic, patient-centred care.

Cultural safety and team-based care

ITC requires a strong commitment to cultural safety, respect, and relationship-building. Trust is developed over time through consistency, listening, and partnership. Many general practitioners find this approach rewarding, as it supports care that reflects patients' social, cultural, and community contexts and aligns with self-determination and Closing the Gap.

General practitioners are well supported through:

- care coordinators managing complex care needs
- clear referral pathways
- clinical and cultural support resources
- learning opportunities in chronic disease management and culturally responsive care.

You are not expected to work in isolation – **shared responsibility is central to ITC.**

What cultural safety looks like in practice

Cultural safety focuses on **how care is delivered**, including:

- building trust through consistency and listening
- respecting patient priorities
- working closely with Aboriginal health workers and care coordinators
- using clear, plain language
- recognising social, cultural, and historical influences on health
- practising cultural humility.

Chronic conditions supported through ITC

ITC commonly supports patients with diabetes, cardiovascular disease, chronic respiratory disease, chronic kidney disease, musculoskeletal conditions, and multiple long-term conditions. Care coordination improves access to services, reduces duplication, and strengthens follow-up, with a focus on long-term wellbeing and self-management.



Case studies (RACGP/ACRRM-aligned)

Regional practice case

Dr Patel works in a regional practice and cares for **Mary**, an Aboriginal woman with multiple chronic conditions. Through ITC, a **Care Coordinator** and **Aboriginal Health Worker** support appointments, follow-up, and culturally safe care. Dr Patel delivers care within scope, using shared decision-making and coordinated planning.

Outcome: Improved engagement, fewer hospital admissions, and sustainable team-based practice.

Remote practice case

Dr Nguyen visits a remote community and works with **Tom**, an Aboriginal man with complex chronic disease and access barriers. ITC supports coordination across distance, specialist visits, and follow-up, with strong involvement from a local Aboriginal Health Worker.

Outcome: Improved continuity, reduced fragmentation, and safe, sustainable remote practice.

Key takeaways

Across regional and remote contexts, Integrated Team Care:

- supports **continuity of care**
- enables culturally safe, patient-centred practice
- shares responsibility within a multidisciplinary team
- operates within structured systems that support safe supervision and escalation
- improves patient outcomes and supports sustainable general practice.

The setting may change, but the principles remain the same: team-based, culturally safe care that meets professional standards and community needs.

Information on the Integrated Team Care program is available online at www.health.gov.au/our-work/integrated-team-care-program

Health assessments and MBS billing

Health assessments are structured consultations that support preventive care, early intervention, and coordinated follow-up. They are distinct from standard consultations and have specific eligibility, documentation, and billing requirements.

The correct use of Medicare Benefits Schedule (MBS) items is part of safe clinical practice and Medicare compliance. You can access information about the MBS online at www.mbsonline.gov.au

Aboriginal and Torres Strait Islander health assessments

MBS Item 715 – Aboriginal and Torres Strait Islander Peoples Health Assessment

- Applies to patients of Aboriginal or Torres Strait Islander descent.
- Available across the lifespan.
- Generally claimable once every nine (9) months.
- Supports access to follow-up services, allied health, and ITC pathways.

This assessment takes a holistic approach, considering physical, psychological, and social wellbeing, and should be informed by patient priorities. Involvement of Aboriginal Health Workers or Practitioners is strongly encouraged where available.

Follow-up services

- **Item 10987:** Follow-up services provided by Practice Nurses or Aboriginal Health Workers under GP supervision.
- Enable structured education, monitoring, and engagement following a completed health assessment.

Non-indigenous health assessments (general population)

Health assessments for non-Indigenous patients are cohort-specific and time-based.

Common GP health assessment items

- Item 701.
- Item 703.
- Item 705.
- Item 707.

The above item numbers are used for eligible patient groups such as:

- adults aged 45–49 years at risk of chronic disease
- older people (75 years and older)
- people with intellectual disability
- refugees and humanitarian entrants
- other specified cohorts.

Each item has minimum time requirements and specific eligibility criteria. Eligibility must be confirmed before billing.

Key billing principles (quick reminders)

- Health assessments are not standard consultations; eligibility must be confirmed before claiming.
- Full documentation is required, including:
 - assessment findings
 - identified risks and needs
 - outcomes, referrals, and follow-up plans.
- Billing should align with practice policy and supervision guidance.
- When unsure, check first with your supervisor or practice manager.
- Safe billing is part of professional accountability and good clinical governance.

Health Assessments and ITC

Aboriginal and Torres Strait Islander health assessments (Item 715) often:

- identify patients suitable for Integrated Team Care (ITC)
- enable access to coordinated allied health and follow-up services
- support long-term, team-based chronic disease management.

Key takeaways

- Use Item 715 for Aboriginal and Torres Strait Islander health assessments.
- Use time-tiered items (70 to 707) for eligible non-Indigenous cohorts.
- Always confirm eligibility, timing, and documentation requirements.
- When uncertain, escalate early – do not guess.
- Good billing supports good care.





Looking after yourself and thriving

Managing the transition

Common feelings you may experience when managing the transition can include overwhelm, fatigue, homesickness, and imposter syndrome. Remember, these are all normal.

Wellbeing strategies

An important step of maintaining your wellbeing is establishing healthy strategies.

- Set realistic expectations.
- Maintain work-life boundaries.
- Rest deliberately.
- Enjoy the northern Queensland lifestyle.
- Watch for burnout signs and seek help.

Staying connected

There are several ways you might consider building connections, which may include:

- maintaining cultural and family contacts
- joining local GP groups
- peer networks (including locum communities and local GP groups)
- workshops and education
- informal peer meetings
- clinical societies.

Where to seek help

You are never expected to manage things alone – support is part of safe general practice.

- **Practice manager:** Your first point of contact for billing processes, workflows, appointment types, and practice policies.
- **GP supervisor or senior GP:** For clinical guidance, documentation review, and help with complex consults or decision-making.
- **Practice nurse team:** There to support you with care plans, health assessments, recalls, and chronic disease workflows.
- **Primary Health Network (PHN):** A central hub for education, practice support, resources, and connections to local services.
- **Professional colleges:** Offer ongoing education, standards, and professional guidance.

Tip: Asking questions early is a strength – it supports patient safety, good habits, and confidence.

Words of wisdom from other locums and practice teams

The weather!
Commonality of certain conditions in the community that are related to lifestyle and culture.

The biggest challenges were navigating paperwork, accreditation, and unfamiliar systems, rather than clinical work. Understanding referral pathways, billing, documentation standards, and local expectations took time. A positive surprise was how supportive colleagues and nursing staff were once I reached out, and how willing people were to help when asked.

Ask questions early and often – no one expects you to know everything. Focus first on learning the systems and workflows, not just clinical guidelines. Keep copies of all documents, stay organised, and don't delay paperwork. Build connections with colleagues, supervisors, and admin staff – they are invaluable. Most importantly, be kind to yourself during the adjustment .

Challenges
Following and finding referral pathways.
Documenting notes in an efficient way.

Working on the communication skills.
Putting some time to check the HealthPathways website.

I wish I had known how much administrative and system-related paperwork is involved, especially around Medicare, RACGP requirements, supervision, and local processes. Clinically, the work is manageable but understanding how the health system functions day-to-day would have reduced stress early on. I also wish I had known how important it is to establish early professional networks and ask for help sooner.

Many northern Queensland patients do not hear the word 'fat' as a diagnosis – they hear it as a judgement. Sensitive, permission based conversations support trust and better outcomes.

Perseverance.
Positivity.



Self-reflection

Prompts:

- What still feels confusing?
- Who can I ask?
- What will I try next week?
- Wins to celebrate.

Practice-specific notes

Sections for:

- Billing rules.
- Key contacts.
- Referral pathways.
- Workflow reminders.

Acronyms

Term	Definition
Aboriginal Medical Service (AMS) / Aboriginal Controlled Health Organisation (ACCHO)	Primary health care services that deliver holistic, comprehensive, and culturally appropriate health service to the Aboriginal and Torres Strait Islander community
ACCHS	Aboriginal Community Controlled Health Service
ACCRM	Australian College of Rural and Remote Medicine
AMS	Aboriginal Medical Service
DHDA	Department of Health, Disability and Ageing
FNQ	Far North Queensland
HHS	Hospital and Health Service
ITC	Integrated Team Care
MBS	Medicare Benefit Schedule
NQPHN	Northern Queensland Primary Health Network
PHN	Primary Health Network
RACGP	Royal Australasian College of Physicians



References

1. GPSA 2024, *FAQ: Effective use of HealthPathways*, viewed 11 May 2026, <https://gpsa.org.au/our-resources/supervision-support/faq-effective-use-of-healthpathways>
2. General Practice Registrars Australia (GPRA) 2026, GPRA, viewed 11 May 2026, <https://gpra.org.au>
3. The Royal Australian College of General Practitioners 2024, *How to use Community HealthPathways*, RACGP, viewed 11 May 2026, <https://www.health.qld.gov.au>
4. Queensland Health 2025, *Smart Referrals*, Queensland Government, viewed 11 May 2026, <https://www.health.qld.gov.au/clinical-practice/innovation/smart-referrals>

