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| **This page is to be completed to summarise the client’s story.** **Complete after the Risk Factor Screening section on page 7. This summary is to be utilised by discipline clinicians to develop a care plan with the client.** **Do not remove this page from the front of the CCST document** |
|  |
| **SUMMARY OF CURRENT LIFE STORY (SITUATION)** |
| Summarise relevant information so client does not need to repeat story; **ask the client.** |
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| **KEY QUESTIONS – clinician to ask client the following three questions and note/action reply** |
| 1. What is important to you?
 |  |
| 1. What would you like to work on or change?
 |  |
| 1. Who is involved in supporting you?
 |  |
|  |  |
| Are there any other concerns that the client would like to discuss today? |  |
| **REFERRALS TO INTERNAL SERVICES *-*** *include* ***priority*** *and* ***reason*** *for referral* |
| Details: |  |
| **REFERRALS TO EXTERNAL SERVICES** |
| Details: |  |
| **BROCHURES TO EXTERNAL SERVICES** |
| Details: |  |
| **CLINICIAN SIGN-OFF** |
|  |  |  |  |
| Name | Signature | Designation | Date |

 |
| **SECTION ONE (to be completed by Program Support)** |
| Date referral received by SCHS:  |  |
| Referral source (organisation and name):  |  |
| Service requested and reason(s) for referral: |  |
| Date referral acknowledged by SCHS with client:  |  |
| Was the referral urgent or routine? |  |
| Date of Client Centered Screening appointment:  |  |
|  |  |
| **CONSUMER INFORMATION** |
| Title: |  | Given name/s: |  | Family name: |  |
| Preferred name: |  | Preferred name recorded on HMS [ ]  |
| Gender: |  | UR Number:  |  |
| Date of birth: |  | Birth date estimated? |  |
| **CONTACT DETAILS** |
| Home Address: |  | ***(tick preferred contact method)***  |
| [ ]  Home:  |  |
| [ ]  Work: |  |
| Postal Address: |  | [ ]  Mobile: |  |
| [ ]  Email\*: |  |
| \*NB: policy does not currently allow SCHS to send identifiable information by email |
| Is the client a carer, care recipient or seeking caring assistance? |  |
| **WHO THE AGENCY CAN CONTACT IF NECESSARY** |
|  | *PRIMARY CONTACT* | *SECONDARY CONTACT* |
| Name:  |  |  |
| Address:  |  |  |
| Postcode:  |  |  |
| Home:  |  |  |
| Work: |  |  |
| Mobile:  |  |  |
| Relationship to client: |  |  |

|  |
| --- |
| **SECTION ONE (to be completed by Program Support)** |
| **DEMOGRAPHICS** |
| Country of Birth: |  | Religion: |  |
| Identify as being of Aboriginal &/or Torres Strait Islander origin? |  |
| Language spoken at home: |  | Communication method: |  |
| Interpreter service required? |  | If yes, language: |  |
| Refugee Status: |  | Asylum Seeker status**:** |  |
| Government pension/benefit status: |  |
| Nature of disability (if on disability pension):  |  |
| **Health care card**: | Card number: |  | Expiry date: |  |
| **Medicare card**: | Card number: |  | Expiry date: |  |

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| **BROKERAGE**  |
| Is the client a **Package Service Recipient**?  |  Yes [ ]  No [ ]  |
| If yes, type of package *(Home care, NDIS or TCP)*: |  |
| Package provider: |  |
| Claim number/details, level of package provided: |  |
| Package provider aware/has approved? |  | Purchase order raised: | Yes [ ]  No [ ]  |

|  |  |  |
| --- | --- | --- |
| Health insurance status: | Insurer name: |  |
| DVA card entitlement: | Card type: |  | Card number: |  |

|  |  |
| --- | --- |
| D904 form (or client advised to get from GP) |  |

|  |  |
| --- | --- |
| Compensable funding source: |  |

|  |  |  |
| --- | --- | --- |
| Does the client have a relevant : |  | *If yes, claim details/number below:* |
| **TAC** claim | [ ]  Yes [ ]  No |  |
| **WorkCover** claim | [ ]  Yes [ ]  No |  |

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| **GENERAL PRACTITIONER (GP)** |
| GP Name:  |  |
| Practice Name: |  |
| Address:  |  |
| Phone:  |  | Fax:  |  |

|  |
| --- |
| **PROGRAM SUPPORT SIGN-OFF *- NB: First two pages need to be completed by on HMS and saved to Drafts.*** |
|  |  |  |  |
| Name | Signature | Designation | Date |

|  |
| --- |
| **SECTION TWO (to be completed by Clinician)** |

|  |
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| **CLIENT HEALTH CONDITIONS *Refer to & update Community Health Program Master Code Set****Does client suffer (or has suffered) from any of the following:*  |
|  | **CURRENT/PAST** | **HEALTHCARE PROVIDERS** |
| **Neurological**(Stroke, ABI, MS ) |  |  |
| **Cardiovascular**(HT, CVD, AMI, IHD) |  |  |
| **Respiratory disease**(COPD, Asthma, Bronchiectasis) |  |  |
| **Gastrointestinal** |  |  |
| **Renal** |  |  |
| **Endocrine**(Diabetes) |  |  |
| **Psychological**(Depression) |  |  |
| **Genital/urological** |  |  |
| **Chronic pain** |  |  |
| **Musculoskeletal** |  |  |
| **Skin problems**(Rashes/wounds) |  |  |
| **Malignancy** (Cancer) |  |  |
| **Sensory** (hearing/vision) |  |  |
| **Surgical** |  |  |
| **Other** |  |  |
| **If 0-16 years** (measles, mumps, chicken pox) |  |  |
| Pediatrician? |  |  |
| **ALLERGIES / ALERTS** Yes [ ]  No [ ]  *If Yes, document below* |
|  |  | *SUBSTANCE/LOCATION* | *REACTION/DETAILS* |
|  | Drug sensitivities |  |  |
|  | Allergies |  |  |
|  | Significant infections(Hepatitis,MRSA,C-DIFF,HIV) |  |  |

Have Allergies / Alerts been updated on HMS? Yes [ ]  No [ ]

|  |
| --- |
| **IMMUNISATIONS** |
| Are the following immunisation’s up to date? |
|  | Influenza |  **Yes** [ ]  **No** [ ]  |
|  | Whooping cough |  **Yes** [ ]   **No** [ ]  **Unsure** [ ]  |
|  | Measles |  **Yes** [ ]  **No** [ ]  **Unsure** [ ]  |
|  |  |
| If client is a **child 0-16 years old,** ask parent/guardian:  |
| “Have you chosen to immunise your child?” |  Yes [ ]  No [ ]  |
| If yes, “Are they up to date?” |  Yes [ ]  No [ ]  |
|  |  |  |
| **MEDICATIONS-** prescription/ over the counter/ vitamins/ supplements etc. |
|  | Name | Strength | Dose | Frequency | Change/comments |
| 1 |  |  |  |  |  |
| 2 |  |  |  |  |  |
| 3 |  |  |  |  |  |
| 4 |  |  |  |  |  |
| 5 |  |  |  |  |  |
| 6 |  |  |  |  |  |
| 7 |  |  |  |  |  |
| 8 |  |  |  |  |  |
| 9 |  |  |  |  |  |
| 10 |  |  |  |  |  |
| 11 |  |  |  |  |  |
| 12 |  |  |  |  |  |
| If taking 6 or more medications on a daily basis, have you had a home medication review in the last year? |  Yes [ ]  No [ ]  |
| **FAMILY HISTORY** |
|  |  |
| Significant family medical history: |  |
| **OTHER SERVICES** *List services currently involved in care* |
| Recent hospital admissions: |  |
| Case manager: |  |
| Need for an advocate: |  |
| Need or use of carer: |  |
| Power of attorney (medical, financial, enduring): |  |
| Does the client have an Advanced Care Plan in place? |  Yes [ ]  No [ ]   |
| **FUNCTIONAL HISTORY *Refer to & update Community Health Program Master Code Set***  |
| Are you able to: |
|   | Without help | With a little help | With a lot of help | Completely unable | Not known |
| Get Dressed? |  |  |   |  |  |
| Prepare your own meal? |  |  |   |  |  |
| Eat your meal? |  |  |   |  |  |
| Go to the toilet? |  |  |   |  |  |
| Shower or bath yourself? |  |  |   |  |  |
| Travel in the community? |  |  |   |  |  |
| Go shopping for groceries? |  |  |   |  |  |
| Do the housework? |  |  |   |  |  |
| Manage your money? |  |  |   |  |  |
| Get out of bed /chair easily? |  |  |  |  |  |
| Walk easily? |  |  |  |  |  |
| Manage your own medication? |  |  |  |  |  |
| Parenting? |  |  |  |  |  |
| Yard work / Gardening? |  |  |  |  |  |
|  |
| If client is a **child 0-16 years old,** do they have any issues with the following: |
|  | Dressing? |  |
|  | Eating? |  |
|  | Toileting? |  |
|  | Sleeping? |  |
|  |  |  |
| **CLIENT SOCIAL CONDITIONS *Refer to & update Community Health Program Master Code Set*** |
| Family stressors:*(relationships, work, carer, parenting)* |  |
| Housing issues:(environment, accommodation, alone) |  |
| Employment status: |  |
| Gambling status: |  |
| Literacy/education issues: |  |
| Legal issues: |  |
| Financial issues: |  |
| Drug or alcohol use issues:*(Type, frequency, impact)* |  |
| Other: |  |
| **RISK FACTOR SCREENING –** *ask client the following questions and note/action & advice* |
| Have you had a general health assessment in the past two years? (GPMP) / Maternal & Child Health Assessment |  |
| Do you have any sexual health concerns – pap smears, mammograms, prostate checks, STI?*Breast Screen (VIC Phone: 132050)*  |  |
| Do you do thirty (30) minutes or more of moderate intensity exercise on most days of the week? |  |
| Have you had a fall in the last twelve months? *Physio / OT referral, Group sessions* [ ]  |  |
| Weight concerns, special diet, swallowing*,* unable to buy food in the last twelve months?*Referral to: Dietician / Speech path / Diabetes / Life* [ ]  |  |
| Have you had a dental check in the last two years?*Referral to Dental*  [ ]  |  |
| Do you smoke? How many daily? For how long? X-smoker?*Are you interested in Quitting? QUIT Brochures* [ ]  |  |
| Is DHHS or Child Protection involved with your family? *Referral to VLA* [ ]  |  |
| Do you have any unpaid fines?(Speeding / Parking) *Referral to VLA* [ ]  |  |
| If you are renting, are you having problems with your landlord? *Referral to VLA* [ ]  |  |
| Do you owe a debt to Centrelink or have you been refused a Centrelink benefits? *Referral to VLA* [ ]  |  |
| Does someone other than you decide how you spend your money? *Referral to VLA*  [ ]  |  |
| Does someone other than you decide the health treatment you receive? *Referral to VLA*  [ ]  |  |
| ***Note****: The following question is to be asked to* ***clients aged 16 years and over*** *and in* ***privacy*** |
| Do you have any past or current issues related to domestic violence or sexual assault that you would like to discuss with a Counsellor? ***(Mallee Sexual Assault Service/ Mallee Domestic Violence Service – 5025 5400)*** |  Yes [ ]  No [ ]  |
| **If yes:** | Note the issue: |  |
| Past or current issue? |  |
| “Would you like to talk to someone from these services?” |  |
|  |
| **SUMMARISE THE CLIENT’S STORY ON THE FIRST PAGE OF THIS DOCUMENT** |

|  |
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| **FINANCES** |
| Is the client **exempt** from fees? | Yes [ ]  No [ ]  |
| If yes, reason for exemption: |  |
| Is the client a **health care card** holder?  |  Yes[ ]  *(see pg. 2 for details*  No [ ]  |
| Will client or someone else be paying for this service? |  Client [ ]  Other [ ]  *see Brokerage section* |
| If the client is paying: |
| Income range (based on DHHS income levels): | Low [ ]  Medium [ ]  High [ ]  |
| If client requests a **fee waiver/reduction**, list reasons why? |  |
| List any additional expenses incurred by the client related to health care *(e.g. pharmaceutical, travel for medical appointments).* |  |
| Explain any conditions of the exemption *(number of appointments, amount of time etc.)* |  |
| Fee waiver request discussed with Manager? |  Yes [ ]  No [ ]  |
| Clinician’s signature: |  |
| Outcome of request  |  Approved [ ]  Not Approved [ ]  |
| Manager’s signature: |  |
| **OUTCOME OF FEE DETERMINATION AS PER CLIENT FEES SCHEDULE** |
| Has the cost of attending service been explained to, and understood by, the client?  |  Yes [ ]  No [ ]  |
| Comments/details: |  |
| **FORMS/DATA SET COMPLETED** |
|  | Consumer Consent to Share [ ]  |  |
|  | HACC Functional Status (HMS) *– where relevant* [ ]  |  |
|  |
| **HANDOUTS PROVIDED** | ***Provided to client*** |
| Sunraysia Community Health Service Brochure | [ ]  |
| Rights & Responsibilities | [ ]  |
| Australian Charter of Health Care Rights | [ ]  |
| Your Information: It’s Private, It’s About you | [ ]  |
| Advanced Care Planning | [ ]  |
| **CLINICIAN SIGN-OFF** |
|  |  |  |  |
| Name | Signature | Designation | Date |