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| **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: | | |  | | | |  | | | |

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| **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 | | |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **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)** |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **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

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| **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 | |  | | | | | | |  | | | | | | |  | | | |  | | | | | | |  | | | |
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| 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 |