Care Coordination Program
Client Assessment Form

Care Coordination Program

Name:	D.O.B:	Date:
Diagnosis/ Reason for referral:		

Allergies (or Nil known)		Reaction:
1.		
2.		
3.		

Hospital Admissions

Admitted:	Discharged:	Reason for presentation:	Complications:

Current Services

Service types:	Organisations providing service:	Contact details:
General Practitioner		
Pharmacist		
Allied Health Services (OT/ EP/ Physio etc)		
Community Nursing		
Diabetes Educator/ Dietitian		
Personal care assistance		
Domestic assistance		
Maintenance		
Consumer directed package (level 1-4)		
Disability ISP		
Mental Health		
Palliative Care		

☐ Advanced Care Planning ☐ Power of Attorney ☐ Public Trustee ☐ Decision Maker

Next of Kin details

First name: Last name:

Address:

City: State: Postcode:

Phone: Mobile: Email:

Relationship

☐ Daughter ☐ Son ☐ Father ☐ Mother

☐ Guardian ☐ Daughter-in-law ☐ Son-in-law ☐ Husband/male partner

☐ Wife/female partner ☐ Friend/neighbour ☐ Other …….

Carer Profile

Carer availability:

Record: (1) Has a Carer; (2) Has no Carer; (3) Not Applicable – Carer not required; (4) Not Applicable ☐

Carer residency status:

Record: (1) Yes – Co-resident Carer; (2) No – Non-resident Carer; (3) Not Applicable ☐

Current threats to carer arrangements

Tick all that apply:

(1) Carer – emotional stress & strain ☐ (2) Carer – Acute physical exhaustion/ illness ☐

(3) Carer – slow physical health deterioration ☐ (4) Carer – factors unrelated to care situation ☐

(5) Consumer – increasing needs ☐ (6) Consumer – other factors ☐

Carer Details

First name: Last name:

Relationship:

Address:

City: State: Postcode:

Phone: Mobile: Email:

Hours of informal care per week ☐ Less than 10 ☐ More than 10

Interpreter details

Interpreter required: ☐ Yes ☐ No

First name: Last name:

Relationship to client: *OR name of interpreter service:*

Interpreter Address:

City: State: Postcode:

Phone: Mobile: Email:

Example Only

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Functional Assessment

When completing assessment consider: Health – consider overall health, age-related problems, disabilities, use of medicines. **Psychosocial** – consider mental health and emotional well-being, personal and social supports, family and personal relationships. **Functional status and activities of daily living** – consider overall health, age-related problems, disabilities. **Health behaviours** – consider lifestyle issues and opportunities for prevention and health promotion. **Determinants of health** – consider living arrangements, housing, carer issues, work, financial, legal.

Item	Question	Score	Record score
1.	***Can you do housework….***		
	Without help (can clean floors etc)?	2	
	With some help (can do light housework but need help with heavy housework)?	1	
	Or are you completely unable to do your housework?	0	
	Who does your housework for you?	0	
2.	***Can you get to places out of walking distance…***		
	Without help (can drive your own car, or travel alone on buses and taxis)?	2	
	With some help (need someone to help you or go with you when travelling)?	1	
	Or are you completely unable to travel unless emergency arrangements are made for a specialised vehicle like an ambulance?	0	
3.	***Can you go out for shopping for groceries or clothes (assuming you have transportation)***		
	Without help (taking care of all shopping needs yourself)?	2	
	With some help (need someone to go with you on all shopping trips)?	1	
	Or are you completely unable to do any shopping?	0	
4.	***Can you take your own medicine…***		
	Without help (in the right doses at the right time)?	2	
	With some help (able to take medication if someone prepares it for you and/or reminds you to take it)?	1	
	Or are you completely unable to take your own medication?	0	
5.	***Can you prepare your own meals…***		
	Without help?	2	
	With some help (meals on wheels)?	1	
	Does someone prepare your meals (unable)	0	
6.	***Can you walk…***		
	Without help (except for cane or similar)?	2	
	With some help from a person or with the use of a walker, or crutches etc	1	
	Or are you completely unable to walk?	0	
7.	***Can you take a bath or shower…***		
	Without help?	2	
	With some help (eg need help getting into or out of the bath)?	1	
	Or are you completely unable to bathe yourself?	0	

NOTES: **TOTAL SCORE:**

Rate what the person is **currently capable** of doing, rather than what they actually do. In assessing capability, take into account not only physical function, but also cognition (such as problems caused by dementia or an intellectual disability) and behaviour (such as unpredictable, challenging behaviour). Consumers able to complete a task with verbal prompting, should not be rated as independent (therefore should be rated as a 1). In rating an item that is irrelevant (for example, if the person has no shops in the vicinity, or does not use any medications), rate based on what the person would be capable of doing if the item was actually relevant to their situation. Item 6 (walking). Clients who are in a wheelchair should be rated as (1) if they are independent, including corners etc or (0) if they are not wheelchair independent.

Activities of Daily Living (ADL's)

1.	***Housework*** Provider of services/ domestic Name: Referral to Tas Care Point Comments:
2.	***Shopping*** Carer/ personal assistance Organisation: Hours/week: Referral to Tas Care Point Comments:
3.	***Meal Preparation*** ☐ Referral to Meals on Wheels Comments: ☐ Referral to Tas Care Point
4.	***Personal Care*** ☐ Grab rails ☐ Toilet ☐ Shower ☐ Hand held shower ☐ Shower stool/chair ☐ Non-slip mats **Carer/ personal assistance** ☐ Yes ☐ No By whom (eg Family Based Care) Referral for assessment/ assistance/ OT/ Tas Care Point/ Other Comments:
5.	***Transport*** ☐ Drives own car ☐ Family/ friends/ carer ☐ Taxi ☐ Community transport ☐ Other Comments:

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6.	***Phone (assess access and use)*** ☐ Landline Comments: ☐ Mobile
7.	***Home and personal safety*** **Fire alarm** ☐ Yes ☐ No Referral Required (Project Wakeup)
	Personal alarm ☐ Yes ☐ No Referral Required (Red Cross)
	Accommodation ☐ Private residence – owned/ purchasing ☐ Private rental ☐ Private residence – public rental ☐ Independent living unit in retirement village
	Comments/ Recommendations:
8.	***Mobility*** ☐ Independent ☐ Uses an aid ☐ Self – Care Aids ☐ Support & Mobility Aids (walker, walking stick) ☐ Communication Aids ☐ Aids for reading (glasses, magnifyer) Falls in last 12 months Comments:
	Recommendation
	☐ Complete falls risk assessment Timed up & go score Referral

Health Assessment

Overall health appearance:	
Comments:	
1	***Cognition*** ☐ Cognitive impairment ☐ Yes ☐ No Comments:
	☐ Memory concerns Recommendations:
	☐ Mini mental (MMSE) Montreal Assessment Referral
	Comments:
2.	***Mental Health*** ☐ K10 Self Assessment Score ☐ History of depression/ anxiety ☐ Concerns about stress ☐ Alcohol/ other drugs Comments:
	Recommendations
	Referral
3.	***Respiratory*** Smoking cessation program ☐ Never smoked ☐ Has quit smoking ☐ Currently smokes If quit, record when ☐ Nil problems ☐ Cough/ wheeze ☐ Consider referral if currently a smoker ☐ Uses medical aids (such as puffers) ☐ Shortness of breath Recommendations
	Referrals
4.	***Diabetes*** ☐ N/A ☐ Type 1 ☐ Type 2 ☐ Medication ☐ BSL Checks ☐ DNE ☐ Dietitian
	Recommendations:
	Referrals:
5.	***Cardiac*** ☐ N/A ☐ On heart medication ☐ Previous cardiac episodes/ hospitalisations
	Recommendations:
	Referrals:

6.	***Skin Integrity***

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	☐ Nil obvious problems/ lesions ☐ Lesions/ sores/ wounds/ rashes
	Comments:
7.	***Foot issues*** ☐ N/A ☐ Diabetes ☐ Oedema ☐ Wounds ☐ Regular reviews/ checks (podiatry) Recommendations
	Referral (Podiatrist)
8.	***Nutrition/ Hydration*** Appetite ☐ Good ☐ Poor Malnourishment screening tool ☐ Shortness of breath Special dietary requirements
	Fluid intake ☐ Adequate ☐ Poor/ cups per day
	__ Teeth ☐ Own teeth ☐ Dentures
9.	***Elimination*** Urinary ☐ Continent ☐ Incontinent ☐ Stress ☐ Urge ☐ Nocturia ☐ Diuretic
	Bowels ☐ N/A ☐ Constipation ☐ Diarrhoea ☐ Faecal Incontinence
	Comments
	Recommendations
	Referrals
10.	***Sleep*** ☐ Nil problems ☐ Poor sleep pattern ☐ Snorer ☐ Average hours/ night ☐ CPAP ☐ Medication
	Recommendations
	Referrals
11.	***Pain Management*** ☐ N/A ☐ Has pain but controlled ☐ Chronic pain (>3 months) ☐ Uncontrolled pain (not controlled medication) Recommendation _____
	☐ Pain assessment tool Comments: _____
	Referral (OPAL) pain clinic
12.	***Communication*** Hearing: ☐ N/A ☐ Difficulty hearing ☐ Hearing aids
	Vision: ☐ N/A ☐ Glasses ☐ Other
	Referral:
	Speech: ☐ Difficulty Comments: _____
	☐ Medical care aids ☐ Car modifications
	Other goods/ equipment (List)

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Medication Risk Identification **Pharmacist Name:**_____

Level of independence	Yes	No
Uses dose administration device ie spacers, inhaler device	☐	☐
Uses dose aid (eg: Webster Pack/ Dosette Box)	☐	☐
Swallowing issues	☐	☐
Other information	☐	☐
Patient assessment	**Yes**	**No**
Can read/ comprehend labels?	☐	☐
Can understand English (other language)	☐	☐
Can open bottles/ packets?	☐	☐
Can measure liquids (or not applicable – write N/A)	☐	☐
Recent Home Medication Review? (Date)	☐	☐
Suspected non-adherence?	☐	☐
Assess adherence by asking:	☐	☐
• People often have difficulty taking their pills for one reason or another. Have you had any difficulty taking your pills?	☐	☐
• About how often would you say you miss taking your pills?	☐	☐

Medication History Checklist	
Apart from prescription medications, the other medications listed are commonly missed by patients.	
☐ Prescription medicines	☐ Vitamins/ natural therapies
☐ Sleeping tablets	☐ Injections
☐ Inhalers, puffers, sprays, sublingual tablets	☐ Medications given weekly/ monthly
☐ Over-the-counter medicines	☐ Pain relief pills/ liquids
☐ Tablets for heartburn, constipation, diarrhoea	☐ Patches, creams, lotions

(For HMR Recommendation, please send the above section to GP)

RECOMMENDATIONS:
Chronic Disease Management: Key MBS Item Numbers (TO BE COMPLETED AT LATER DATE)
General Practice Management Plans (GPMP) & Team Care Arrangements (TCA)

Existing CDM Claims		
☐	707	Prolonged Health Assessment
☐	721	Preparation of a GP Management Plan (GPMP)
☐	732	Review of a GPMP or Coordination of a Review of a TCA
☐	723	Coordination of Team Care Arrangements (TCA)
☐	729	Contribution to a Multidisciplinary Care Plan (MCP)
☐	900	Home Medicines Review (HMR)
☐	2521	Diabetes Cycle of Care (level C Long)
☐		GP Mental Health Plan
Potential CDM Claims		
☐	707	Prolonged Health Assessment
☐	721	Preparation of a GP Management Plan (GPMP)
☐	732	Review of a GPMP or Coordination of a Review of a TCA
☐	723	Coordination of Team Care Arrangements (TCA)
☐	729	Contribution to a Multidisciplinary Care Plan (MCP)
☐	900	Home Medicines Review (HMR)
☐	2521	Diabetes Cycle of Care (level C Long)

Immunisation			
See Adult schedule			
☐ Fluvax	☐ Pneumovax	☐ Tetanus	☐ Pertussis

Example

Recommendations

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