



Australian Government
Department of Social Services



myagedcare

NATIONAL SCREENING AND ASSESSMENT FORM

Event Details - Section 1

Date on which referral received

Start date

Date of
Assessment / Screening

Completion date

23/08/2016

23/08/2016

23/08/2016

Priority for assessment

Medium

Completion Status

Finished

What type of assessment will be conducted?

Home Support Assessment

Reason for not conducting a
telephone screening

Office Use Only:

Aged Care Identifier

AC27244292

OPA Record Id (Instance Id)

1-4RV62GD

Assessment Read Only Indicator ☐

NSAF Questionnaire Version Number

v1.0

Event details - Section 2

Referral

Source of Referral

Reason for Referral

Other (source)

Referrer Name

Referring organisation

Contact number

Unit no./Street
number

Street line 1

Street line 2

Suburb

State/Territory

Postcode

Country

Address Type

Consent

Consent obtained

Provided

No consent reason

Persons consulted

☐ Are there other participants who have been consulted prior to the assessment?

Other participants consulted

Contact setting

First face-to-face contact date / date of episode

23/08/2016

Setting

In the client's home

Primary source of information

Information primarily collect from

The client

Name/organisation

Participants in Screening/Assessment

☐ Are there other participants involved?

Other participants involved- please specify

Current approvals

Level

Home Care Package Level 2

Date care ceases

Care Type

Home Care Package Level 2

Has the client previously participated in

Screening

☐

Home Support Assessment

☐

Comprehensive Assessment

☐

Other Assessment

☐

Specify

Unable to determine

☐

Comments
/Further information

Registration

Title	Given Name	Middle Name	Surname
Mrs	Rae	Marion	Madden

Preferred Name

Date of Birth	Age (auto-generated from DoB)	<input type="checkbox"/> Date of birth estimated
10/08/1939	77	

Medicare Card	21238146972	DVA Number	
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Email Address

No fixed address	<input type="checkbox"/>	Preferred phone	Home
Phone - home	+610265511800	Phone - mobile	+610457722515
Phone - business		Phone - other	

Addresses

Address Type	Address
Home	18 KANANGRA Drive, TAREE, NSW, 2430, Australia

Client Demographics

Gender	Marital Status
Female	Widowed

Country of Birth	Ethnicity	Preferred Language
Australia	Australian	English

Do you identify as being Aboriginal and/or Torres Strait Islander?	Are you a veteran or war widow/widower?
No - Neither	

DVA Entitlement	Who do you live with?	Type of accommodation
No DVA entitlement	Lives alone	PR Client Owns/Purchasing

Comments/information

House

Communication Difficulties

Does the client ever need help to communicate (to understand or be understood by others)?

If "Yes", please specify the type of communication difficulties with supporting comments below

Type of difficulty

Any other

TIS

NRS required

☐

Comments

Additional Information

Emergency contact

GP details

Enduring Power of Attorney (EPOA) / Guardian / Administrator

Government pensions/Benefits

Insurance

Private Health Insurance

Reason for contact

How may I help you today?

Rae has called to have an assessment completed as she was scheduled in July to have an assessment, however due to hospitalisation, the assessment could not be completed. Rae needs a Meals service as she is unable to prepare her own meals.

Key circumstances triggering contact

- ☐ Hospital Discharge
- ☐ Fall(s)
- ☐ Medical Condition
- ☐ Change in Cognitive Status
- ☒ Change in care needs
- ☐ Concern about increasing frailty
- ☐ Carer burden/issues
- ☐ Change in caring arrangements
- ☐ Change in living arrangements

Specify

- ☐ Sudden change in circumstances

Specify

- ☐ Risk of vulnerability

- ☐ Other

Other reason for contact

- ☐ Unable to determine

What is concerning you most about your current situation?

Unable to transfer without help. Unstable when transferring.

How have you been managing with this up until now?

Client manages with a 4 wheel walker. Client has a walking stick but prefers to use walker. Client had a fall in Feb 2015 and has further falls.

Further comments on Reason for Contact

meals.

SOCIAL DOMAIN

Current Support

☐ Does the client currently have a support plan in place?

Current support plan - details

CURRENT GATEWAY KNOWN SERVICES

Following are those services for which:

1. The service has commenced for the client; and
2. That same service has not yet ended.

Program	Service Type	Service Sub-type	Date of commencement	Service Provider
CHSP	Meals	At Home	05/09/2016	MSS
CHSP	Transport	Indirect (through vouchers or subsidies)	23/08/2016	Community Transport - Wingham, Greater Taree (Manning Valley)

Are you currently receiving support?

		Formal	Informal	From whom (if known)?
Communication	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Self care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Movement activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Health care tasks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Moving around places at or away from home	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Home maintenance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Domestic Assistance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Meals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Transport	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Activities involving social and Community participation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<div></div>
Other		<input type="checkbox"/>		
Other - specify	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<div></div>

☐ Not applicable
 ☐ None
 ☐ Unable to determine

Comments/Further information

Rae currently receives lawn mowing and domestic assistance fortnightly.

Current Support - Programmes

Are you currently receiving support or assistance from any of the following programs (if known)?

☒ Home and Community Care (HACC)

Time Period/End Date
Client has home maintenance for lawnmowing and also has domestic assistance for 1.5 hours per fort.

☐ Day Therapy Centre (DTC)

☐ National Respite for Carers Program (NRCP)

☐ Assistance with Care and Housing for the Aged (ACHA)

☐ Home Care Level 1 or 2

☐ Home Care Level 3 or 4

☐ Transition care

☐ Veterans home care

☐ Other

Other - Please specify

☐ None

☐ Unable to determine

Are you currently receiving respite in an aged care facility? No

Receiving respite in aged care facility- specify

Has the client or their carer used residential or community based respite care in the last 12 months? None

Residential or Community based respite- Details

Carer

Client supporting someone else

Are you supporting or looking after another person? No

First name, last name

Relationship to client

Lives with client ☐ Date of Birth Age

Contact Details

Carer overview - Client perspective

What type of care does the carer provide? How often?

Rae's daughter works full time but takes Rae to appointments.

Have there been recent significant changes in carer or family support arrangements?

Specify

Does the carer experience any difficulties or have any concerns with the caring arrangement?

Difficulties and concerns

Difficulties and concerns - details

- ☐ Carer - emotional stress and strain
- ☐ Carer - acute physical exhaustion/illness
- ☐ Carer - slow physical health deterioration
- ☐ Carer - difficulties with specific tasks (lifting, managing medicines etc)
- ☐ Carer - factors unrelated to care situation
- ☐ Client - increasing needs
- ☐ Client - other factors
- ☐ Other

Are carer arrangements sustainable without additional services or supports?

Carer sustainability - details

EMERGENCY CARE PLAN

Is there an emergency care plan in place if something should happen to the carer?

Emergency care plan - details

Comments/ further information

Carer Overview - Carer Perspective

What type of care do you provide? How often?

Carer - Do you receive any support in your caring role (e.g. from family, friends, community, other organisations)?

Support in caring role - details

Do you have any other responsibilities (eg. Employment, education)?

Other responsibilities - details

OTHER CARING RESPONSIBILITIES

Do you have any other caring responsibilities

Other caring responsibilities - details

Do you receive a carer payment or allowance?

Do you experience any difficulties or have any concerns with the caring arrangement?

Difficulties and concerns

- ☐ Carer - emotional stress and strain
- ☐ Carer - acute physical exhaustion/illness
- ☐ Carer - slow physical health deterioration
- ☐ Carer - difficulties with specific tasks
- ☐ Carer - factors unrelated to care situation
- ☐ Client - increasing needs
- ☐ Client - other factors

Difficulties and concerns - details

SUSTAINABILITY OF CARING ARRANGEMENTS

Are your caring arrangements sustainable without additional services or supports?

Carer sustainability - details

What support(s) would assist you in managing your caring role?

EMERGENCY CARE PLAN

Is there any emergency care plan in place if something should happen to you?

Emergency care plan - details

Comments/information

Client as Carer Overview

What type of care do you provide? How often?

Carer - Do you receive any support in your caring role (e.g. from family, friends, community, other organisations)?

Support in caring role - details

Do you experience any difficulties or have any concerns with the caring arrangement?

Difficulties and concerns

- ☐ Carer - emotional stress and strain
- ☐ Carer - acute physical exhaustion/illness
- ☐ Carer - slow physical health deterioration
- ☐ Carer - difficulties with specific tasks
- ☐ Carer - factors unrelated to care situation
- ☐ Client - increasing needs
- ☐ Client - other factors
- ☐ Other

Difficulties and concerns - details

EMERGENCY CARE PLAN

Is there any emergency care plan in place?

Emergency care plan - details

SUSTAINABILITY OF CARING ARRANGEMENTS

Are your caring arrangements sustainable without additional services or supports?

Carer sustainability - details

Comments/ Further information

Family, Community Engagement and Support

Describe the client's personal and family support networks

Client has a good family support and neighbour support.

Describe the client's involvement in community based activities, the client's interests, hobbies or special interest groups

Client is unable to transfer by herself and needs assistance.

Describe the client's engagement with family, social/community groups, clubs, etc

Client has frequent contact with family and neighbours.

Have there been recent changes in your family, cultural and social situation?

No

Changes in family, cultural or social situation- Details

Comments/information

Details of any information regarding the client's social situation, cultural background, or diverse needs that may need to be considered as part of a recommendation for support

none

MEDICAL DOMAIN

Health Conditions noted in Screening

Rae was hospitalised for 5 weeks because she had a few falls which caused severe pain and reactions to medications.

Health Conditions

Health or mental health condition or disability

Physical deterioration—general

Diagnosis status

Receiving treatment or support for these conditions

No

Specify

client would like to return to the Stepping On Programme

Impacts on day to day activities?

Yes

Specify

Client feels unstable when transferring

General observations

client is aware of her needs

What are your main health and wellbeing challenges?

transferring and mobility

What do you do to take care of yourself and your health?

client takes medications daily and receives assistance from neighbour

Clinical services the client receives

Relevant Medical History

Medications

Are you taking any prescribed medication?

Yes

How many types?

11

Allergies

Do you have any allergies and/or sensitivities?

Not sure/unable to determine

Details of allergies and/or sensitivities

Healthcare

Have you had a GP check up in the past 3 months?

Yes

Do you have any regular health checks?

Yes

Health checks - describe

general check ups and medications review

Have you been discharged from hospital in the past three months?

Yes

Hospital Stay - details

Client was admitted into Wingham Rehab Hospital for mobility concerns. Client received physio and hydrotherapy. Client was happy with the Physiotherapy given daily.

Was the use of aids/equipment recommended as a result of the hospital stay?

Yes

What aids were recommended?

4 Wheel walker and walking stick.

Were the aids/equipment implemented?

No

Aids and equipment details

Comments/ further information

Oral Hygiene

Do you have any oral health concerns?

No

Oral health concern details

Have you had a dental check-up in the last 12 months?

Not sure/unable to determine

Do you have any problems with your teeth mouth, or dentures?

No

Do you experience any pain or sore teeth when you eat?

No

Do you have any problems swallowing?

No

Appetite

How is your appetite?

Client has a good appetite.

Have you noticed any loss of taste?

No

Have you been eating poorly as a result of decreased appetite?

No

Decreased appetite - details

Weight loss

Have you lost any weight without trying, or had any other nutritional concerns in the past 3 months?

Yes

Weight loss - details

Since hospital stay.

Fluid intake

Do you regularly drink more than 8 cups of fluid a day?

Yes

Have you recently decreased your fluid intake?

Specify

Skin conditions

Do you have any major skin condition(s)?

No

Select the conditions

- ☐ Pressure ulcer
- ☐ Other skin ulcer
- ☐ Healing surgical wounds
- ☐ Other skin tears, cuts or lesion
- ☐ Other Skin Problems(eg.bruises,rashes,itching,eczema)

Do any of these require treatment?

No

Treatment - details

Bladder and Bowel

Do you have any bladder or bowel issues that affect your lifestyle?

Yes

Bladder issues ☐

Bowel issues ☒

Have you discussed these problems with anyone (e.g. GP, continence advisor)?

Yes

Bladder/bowel - Details

Client takes coloxyl due to other medications.

Would you like to discuss continence issues with a continence advisory service?

No

Health Literacy

Do you have difficulty understanding information, instructions or written material received from doctors or other health professionals?

No

Comments regarding health literacy

Comments/ Further information

PHYSICAL DOMAIN

Have you had two or more falls in the past 12 months?	Yes
What caused the falls?	Rae has had several falls.
Are you afraid of falling?	Often
Does the Client have difficulty with:	
Balance	<input type="checkbox"/>
Posture	<input type="checkbox"/>
Endurance	<input type="checkbox"/>
Gait	<input type="checkbox"/>
Tremor	<input type="checkbox"/>
Other	<input type="checkbox"/>
Specify	

Pain

Have you had any bodily pain during the past four weeks?	Moderate
How does the pain impact on your daily activities?	No
What strategies do you use to help manage the pain?	Client uses patches for pain.

Vision, Hearing and Speech

Vision	Yes
Vision concerns addressed	Yes
Vision concerns details	client is due to have an eye test.
Hearing	No
Hearing concerns addressed	
Hearing concerns details	

Speech

Speech concerns addressed

Speech concerns details

Changes In Vision

Have you experienced changes with your vision in the past 3 months, or experienced any new eye conditions?

Do you have difficulty with vision, even with the glasses?

When did you last have your eyes checked?

Sleep Difficulties

Do you experience any difficulties sleeping (e.g. difficulty falling asleep, fragmented sleep, insufficient sleep)?

Sleeping difficulties details

Alcohol

Do you drink alcohol?

Are you concerned about how much alcohol you drink?

Specify

How often do you have six or more standard alcoholic drinks on any one occasion?

Is alcohol consumption causing problem(s) for you?

Alcohol difficulties details

Smoking

Do you smoke or have you smoked previously?

When did you quit smoking?

Not stated/unknown (when the client quit smoking) ☐

How many cigarettes do you smoke per day?

Not stated/unknown (how many cigarettes per day)

☐

Do you wish to quit smoking?

Physical Activity

In the past week, how often have you completed more than 30 minutes of physical activity (enough to raise breathing rate)?

none

What activity do you enjoy the most?

Client used to run an indoor netball competition and cannot do at the moment.

Would you like to do more physical activity?

Yes

More physical activity - details

Would like to return to running competitions.

What is stopping you from doing it?

Client has not driven since January 2016 and does not feel confident at the moment. There are other colleagues who offer lifts.

Are you concerned about your level of physical activity?

Yes

Concerns about physical activity - details

Client would like to feel more confident.

Comments/ further information

Function

Can the client get to places outside of walking distance?

Completely unable to travel unless emergency arrangements are made for a specialised vehicle like an ambulance

Who/what assists?

- ☐ No one
- ☐ Carer
- ☐ Service Provider
- ☒ Aids and equipment
- ☒ Home modifications
- ☒ Other

Will assistance be required to fulfil need?

Yes-Non-Episodic

Comments

Rae relies on her daughter to take her where she needs to go.

Can the client go shopping for groceries or clothes (assuming client transportation)?

Who/what assists?

- ☐ No one

Will assistance be required to fulfil need?

Yes-Non-Episodic

With some help (need someone to go with the client on all shopping trips)

- ☐ Carer
- ☐ Service Provider
- ☐ Aids and equipment
- ☐ Home modifications
- ☒ Other

Comments

Rae is assisted by her daughter and grandson.

Can the client prepare their own meals?

With some help (can prepare some things but unable to cook full meals themselves)

- ☐ No one
- ☐ Carer
- ☐ Service Provider
- ☐ Aids and equipment
- ☐ Home modifications
- ☒ Other

Who/what assists?

Will assistance be required to fulfil need?

Yes-Non-Episodic

Comments

Rae has frozen meals and can make sandwiches but requires a meal service.

Can the client do housework?

With some help (can do light housework but may need help with heavy work)

- ☐ No one
- ☐ Carer
- ☐ Service Provider
- ☐ Aids and equipment
- ☐ Home modifications
- ☒ Other

Who/what assists?

Will assistance be required to fulfil need?

Yes-Non-Episodic

Comments

Receives fortnightly domestic assistance.

Can the client take their own medicine?

With some help (able to take medicine if someone prepares it for the client and/or reminds the client to take it)

- ☒ No one
- ☐ Carer
- ☐ Service Provider
- ☐ Aids and equipment
- ☐ Home modifications
- ☐ Other

Who/what assists?

Will assistance be required to fulfil need?

No

Comments

Uses a weekly planner.

Can the client handle their own money?

Without help (pay bills etc)

Who/what assists?

- ☐ No one
- ☐ Carer
- ☐ Service Provider
- ☐ Aids and equipment
- ☐ Home modifications
- ☐ Other

Will assistance be required to fulfil need?

Comments

Can the client walk?

With some help from a person or with the use of a walker, or crutches etc

Who/what assists?

- ☐ No one
- ☐ Carer
- ☐ Service Provider
- ☒ Aids and equipment
- ☐ Home modifications
- ☐ Other

Will assistance be required to fulfil need?

Yes-Non-Episodic

Comments

Rae is unable to walk without her walker.

Can the client take a bath or shower?

Without help

Who/what assists?

- ☐ No one
- ☐ Carer
- ☐ Service Provider
- ☐ Aids and equipment
- ☐ Home modifications
- ☐ Other

Will assistance be required to fulfil need?

Comments

Dressing

Independent (including buttons, zips, laces etc)

Who/what assists?

- ☐ No one
- ☐ Carer
- ☐ Service Provider
- ☐ Aids and equipment
- ☐ Home modifications
- ☐ Other

Will assistance be required to fulfil need?

Comments

Eating

Who/what assists?

Will assistance be

Independent (food provided within reach)

- ☐ No one
☐ Carer
☐ Service Provider
☐ Aids and equipment
☐ Home modifications
☐ Other

required to fulfil need?

Comments

Transfers

Minor help (verbal or physical)

- Who/what assists?
- ☐ No one
☐ Carer
☐ Service Provider
☐ Aids and equipment
☐ Home modifications
☒ Other

Will assistance be required to fulfil need?

Yes-Non-Episodic

Comments

Uses a walker.

Toilet Use

Independent (on and off, dressing, wiping)

- Who/what assists?
- ☐ No one
☐ Carer
☐ Service Provider
☐ Aids and equipment
☐ Home modifications
☐ Other

Will assistance be required to fulfil need?

Comments

Comments/ Further information

Client needs meals, Physiotherapy, Stepping On Programme and Transport by way of taxi vouchers.

PSYCHOLOGICAL DOMAIN

Have you experienced any changes in your memory and thinking?

No

Changes in memory and thinking - details

Over what timeframe have you experienced these changes?

How is the memory loss impacting on your everyday activities?

Is the client aware of time and place?

Yes

Are there any reported changes in the client's personality?

No

Changes in client's personality- details

Has there been a change in the client's behavior?

No

Specify

How are these behaviors impacting on the client?

Is the client receiving any help or assistance with these?

Assistance with behaviors- details

Does the client have any memory problems or get confused?

No

Evidence of confusion/memory problems

Behavioral Concerns

No

Evidence of behavioral problems

Are there any concerns about psychological symptoms associated with memory loss?

No

Specify?

Are there any cognitive or mental problems that may need to be considered as part of the recommendation for support?

No

Details of cognitive or mental health problems that may need to be considered

Do you have anyone that assists you in making health or lifestyle decisions?

Yes

Who assists?

Marion Campbell

Relationship to client

Son or daughter

Do you have anyone that assists you in making financial decisions?

Yes

Who assists?

Marion Campbell

Relationship to client

Son or daughter

Are there any concerns regarding the client's decision making capabilities?

Comments/ Further information?

Rae's medication can sometimes disorientate her and cause hallucinations.

Psychosocial

Nervous

None of the time

Depressed

Some of the time

Lonely

A little of the time

Have you experienced one or more stressful events over the past three months?

No

Stressful events - details

Has the client had a sudden change in mental state recently?

No

Mental state - details

Is the client socially isolated?

No

Social isolation- details

Comments/ Further information

Client was happy to answer queations.

Home and personal safety overview

How are you managing at home (e.g. with stairs, floors, etc)?

Client does not feel very confident at the moment and wishes to attend the Stepping On Programme, Taree.

Is the client self-neglecting of personal care, nutrition or safety?

No

Self neglect - details

Are there any risks, hazards or concerns to you in your home?

No

Risks, hazards, concerns- details

Would any equipment or modification to your home assist you to maintain your independence and/or safety?

No

Modifications/equipment- Details

Does the home environment have any barriers to the client's independence?

No

Barriers - Details

Do you have a personal alarm to use in emergencies?

No

Has the personal alarm been checked in the last 12 months?

Is there a working smoke alarm in your house?

Yes

Has the smoke alarm been checked in the last 12 months?

Yes

Is the client at risk and in need of more than one smoke alarm?

Not sure/unable to determine

Smoke alarms- comments

Do you have a personal emergency plan in case of fire, heat wave or flood?

Yes

Do you drive a motor vehicle?

Yes

Are there any concerns in relation to the client being able to drive?

Yes

Concerns with driving - details

Client does not feel confident at the moment.

Do you have any concerns with your living arrangements?

No

Concerns with living arrangements- details

Do you have any concerns about your financial situation?

No

Concerns with financial situations - details

Is the client experiencing financial hardship threatening the use of services essential for supporting them at home?

No

Details of financial hardship

Are you afraid of someone who hurts, insults, controls or threatens you, or who prevents you from doing what you want?

No

Who are you afraid of and what is their relationship to you?

What form does this take?

Is it becoming worse or happening more frequently?

Worsening - details

Are you scared for your safety?

Scared for safety - details

Does the client have any legal issues that may affect services (e.g. AVO)?

No

Legal issues - details

Comments/ further information

Complexity Indicators

Person is living in inadequate housing or with insecure tenure or is already homeless which compromises their health, well being and ability to remain living in the community.

No

There is a risk of, or suspected or confirmed abuse.

No

Person has emotional or mental health issues that significantly limits self care capacity, requires intensive supervision and/or frequent changes to support.

No

Person is experiencing financial disadvantage or other barriers that threaten their access to services essential for their support.

No

Person has experienced adverse effects of institutionalisation and/or systems abuse (e.g. spending time in institutions, prisons, foster care, residential care or out of home care) and is refusing assistance or services when they are clearly needed to maintain safety and well-being.

No

Person is exposed to risks due to drug and/or alcohol related issues and is likely to cause harm to themselves or others.

No

Person is exposed to risks or is self-neglecting of personal care and/or safety and likely to cause harm to themselves and others

No

Person has a memory problem or confusion that significantly limits self care capacity, requires intensive supervision and/or frequent changes to support.

Yes

Risk Of Vulnerability Cohort

- | | |
|--|-------------------------------------|
| Aboriginal or Torres Strait Islander | <input type="checkbox"/> |
| Veteran | <input type="checkbox"/> |
| Change in family/carer support arrangements | <input type="checkbox"/> |
| Refugees, asylum seekers or recent migrants without support | <input type="checkbox"/> |
| Lesbian, gay, bisexual, transgender, intersex or other diverse individuals | <input type="checkbox"/> |
| Culturally and linguistically or ethnically diverse individual | <input type="checkbox"/> |
| Socially isolated individual | <input checked="" type="checkbox"/> |

Complexity Indicator Assessment

- Does the client have one or more complexity indicators that impact on their ability to live independently in the community? ☒
- Does the risk or issue warrant urgent intervention and/or support to minimise deterioration ☒
- Does the client present with indicators that impede access to delivery of aged care services? ☐

Comments/information related to Complexity Indicators Profile

Summary of Needs

Identified Need	Nature of Need
Shopping	Non-episodic
Housework	Non-episodic
Meals preparation	Non-episodic
Transport	Non-episodic
Walking	Non-episodic
Transfers	Non-episodic

Is it evident that the client is dependent on support in order to be able to remain living in the community?

Yes

Reason

client needs reassurance when mobilising.

Is it evident that the client requires ongoing support (i.e. case management or care coordination) or has ongoing multiple needs that impact on their ability to remain living in the community?

Yes

Reason

Client would like meals services, Physiotherapy, Community Transport, Stepping On Programme.

Is linking support to services in aged care and/or in other sectors required to address issues and barriers?

No- Client or informal support is able to self-manage linking support

Specify

Other consideration

Consideration
Falls
Health conditions
Significant Psychosocial concerns
Pain
Concerns around physical activity
Recent discharge from hospital
Vision/hearing/speech
Weight loss/appetite concerns
Continence issues

Event Summary for Home Support Assessment

Event completion

Event Completion



Event completion date

23/08/2016

Reason for non-completion
(including follow-up actions
required)

Event Summary

Comments/
Further Information

SUPPLEMENTARY ASSESSMENT TOOLS

Please nominate the required Supplementary Assessment Tools (SATs):

- ☐ K-10
- ☐ Caregiver Strain Index
- ☐ Mini Nutritional Assessment
- ☐ OARS-ADL
- ☐ Barthel Index of Activities of Daily Living (ADL)
- ☐ SA Oral Health Referral Pad
- ☐ Oral Health Assessment Tool (OHAT)
- ☐ Revised Urinary Incontinence Scale (RUIS)
- ☐ Revised Faecal Incontinence Scale (RFIS)
- ☐ Brief Pain Inventory
- ☐ Residents Verbal Brief Pain Inventory
- ☐ Abbey Pain Scale
- ☐ Alcohol Use Disorders Identification Test (AUDIT)
- ☐ KICA-ADL
- ☐ KICA-COG
- ☐ KICA-Carer
- ☐ SMMSE
- ☐ Rowland Universal Dementia Assessment Scale (RUDAS)

- ☐ Geriatric Depression Scale (GDS)
- ☐ Informant Questionnaire on Cognitive Decline in the Elderly (IQCODE); short version