

# KOOWEERUP REGIONAL HEALTH SERVICE MY AGED CARE REFERRAL QUESTIONS

**THIS FORM IS TO BE USED IF A REFERRAL IS REQUIRED TO MY AGED CARE**

Name:		Date of Birth:      /      /	
Address:			
			Postcode:
Do you have an active Home Care Package or NDIS Package?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
If no, you will need to proceed to referral.			
Aboriginal or Torres Strait Islander?		<input type="checkbox"/> A <input type="checkbox"/> TSI <input type="checkbox"/> Both <input type="checkbox"/> None	
Interpreter required?		<input type="checkbox"/> Yes <input type="checkbox"/> No Preferred Language:	
Medicare Number:		D.V.A. Number:	
Telephone Number:		Mobile Number:	
Carer Support Person?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Name of Carer Support Person:			
Telephone Number of Carer Support Person:			
Address of Carer Support Person:			
			Postcode:
Is Carer Support Person required at appointments?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
G.P. Name:		G.P. Telephone Number:	
G.P. Medical Centre:			
Diagnosis:			
Client Concerns:			
Health concerns			
Recent falls			
Pain			
Memory loss or confusion			
Loneliness/social isolation			
Safety at home			
Special needs			
Weight loss/nutrition concerns			
Carer stress			
Incontinence			

Client function based on your knowledge, is the client able to:

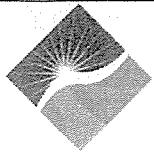
	Without help	With a little help	With a lot of help	Completely unable	Not known
Get out of bed easily?					
Get dressed?					
Eat their meals?					
Got to the toilet?					
Walk easily?					
Shower or have a bath?					
Manage their own medication?					
Travel in the community?					
Go shopping for groceries?					
Prepare their own meals?					
Do housework?					
Manage their money?					

I confirm that I give permission for the above information to be used to make a referral to My Aged Care on my behalf:

Name:
Signature:
Date:        /        /

Located under Policies and Procedures/Forms

[illegible]



**Kooweerup Regional  
Health Service  
Treatment/Care Plan and  
ISBAR Handover Tool**

(INSERT BRADMA LABEL)

**Nurse and Consumer to sign after each Support Care Plan Change/Update**

Allergies: \_\_\_\_\_

Case Management Meetings Required ☐ Yes ☐ No

Care Co-Ordination Required ☐ Yes ☐ No

Is a Care Pathway (in place) describe: \_\_\_\_\_

Services required or already involved:

☐ MECWA ☐ O.T. ☐ Physio ☐ Podiatrist/Foot Care ☐ Dietitian ☐ Speech ☐ Social Worker  
☐ G.P. ☐ Other: \_\_\_\_\_

**UPDATE AT THE END OF EACH VISIT**

**INI DATE:**

**ADMISSION ASSESSMENTS**

Falls	<input type="checkbox"/> Low <input type="checkbox"/> Medium <input type="checkbox"/> High	Action Required <input type="checkbox"/> Yes <input type="checkbox"/> No
Braden Scale	<input type="checkbox"/> LR <input type="checkbox"/> AR <input type="checkbox"/> MR <input type="checkbox"/> HR <input type="checkbox"/> VHR	Action Required <input type="checkbox"/> Yes <input type="checkbox"/> No
Nutritional Risk	<input type="checkbox"/> Yes <input type="checkbox"/> No	Action Required <input type="checkbox"/> Yes <input type="checkbox"/> No
Client Risk	<input type="checkbox"/> Heat <input type="checkbox"/> Fire <input type="checkbox"/> Flood <input type="checkbox"/> Vulnerable	Added to Register <input type="checkbox"/> Yes

Client Admission Goal (clients own words):

Client Plan of Care:

Client Discharge Goal (clients own words):

Client Discharge Plan:

**RESTORATIVE SUPPORT CARE PLAN**

Date	Visit Times	Issues/Problems Situation & Background	Goals/Objectives Assessment & Recommendations	Date Goal/Objective Met or Reviewed	Initial	
					Nurse	Client

Implemented: July, 2013

Reviewed: July, 2016

HP/sg/10507b



**Kooweerup**  
REGIONAL HEALTH SERVICE

## KOOWEERUP REGIONAL HEALTH SERVICE CLIENT GOAL DIRECTED CARE PLAN

NAME:	DATE CARE PLAN DEVELOPED:
PEOPLE INVOLVED:	DATE FOR REVIEW

CURRENT SITUATION:
WHAT DO YOU WANT TO ACHIEVE BY WORKING TOGETHER?

CARE PLAN PROVIDED TO:			
CLIENT:	<input type="checkbox"/> YES <input type="checkbox"/> NO	NAME:	CLIENT CONSENT: <input type="checkbox"/> YES <input type="checkbox"/> NO
FAMILY/CARER	<input type="checkbox"/> YES <input type="checkbox"/> NO	NAME/S:	CLIENT CONSENT: <input type="checkbox"/> YES <input type="checkbox"/> NO
OTHER STAFF:	<input type="checkbox"/> YES <input type="checkbox"/> NO	NAME/S:	CLIENT CONSENT: <input type="checkbox"/> YES <input type="checkbox"/> NO
OTHER SERVICES:	<input type="checkbox"/> YES <input type="checkbox"/> NO	NAME/S:	

### CLIENT ACKNOWLEDGMENT: I UNDERSTAND AND AGREE TO THIS CARE PLAN:

CLIENT/CARER SIGNATURE:	STAFF SIGNATURE:
CLIENT/CARER NAME:	STAFF MEMBER'S NAME:
DATE: / /	DATE: / /

**PLEASE SEE OVER**

GOAL (what do you want to achieve)	ACTIONS (how will you do it)	WHO IS RESPONSIBLE Client/Service	TIMEFRAME (by when)	COMPLETED	ACHIEVEMENTS (where to from here)	SIGN AND DATE

# KOOWEERUP REGIONAL HEALTH SERVICE

## ALLIED HEALTH – FEE SCHEDULE

YOUR INCOME LEVEL				
PLEASE TICK THE CORRECT BOX – FIGURES ARE “BEFORE TAX”				
	LOW	MEDIUM	HIGH	✓ YOUR LEVEL
PENSION				
HEALTH CARE CARD				
INDIVIDUAL	LESS THAN \$38,157	\$38,157-\$83,487	MORE THAN \$88,487	
COUPLE	LESS THAN \$58,488	\$58,438-\$111,608	MORE THAN \$111,608	
FAMILY WITH ONE CHILD	PLUS \$6,195 PER ADDITIONAL CHILD			

### ARE THERE ANY FACTORS THAT AFFECT YOUR ABILITY TO PAY?

### ARE THESE COSTS SHORT TERM OR ONGOING? (Please circle response)

SHORT TERM	ONGOING
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I AGREE THAT THIS INFORMATION CAN BE USED TO SET FEES FOR THE SERVICE(S) I RECEIVE AND ACKNOWLEDGE THAT THE FEE I AM CHARGED WILL BE REVIEWED FROM TIME TO TIME AT EITHER MY OR THE KOOWEERUP REGIONAL HEALTH SERVICE'S REQUEST.

YOUR SIGNATURE:

DATE:

### FACTORS AFFECTING ABILITY TO PAY

- Aids/equipment, i.e. incontinence products.
- Specialist care.
- Additional school costs.
- Special foods.
- Temporary care/respite.
- Special clothing.
- Medical supplies.
- Pharmaceutical or medication costs.