KOOWEERUP REGIONAL HEALTH SERVICE

Home Care
Initial Needs & Assessment Form

(INSERT BRADMA LABEL)

Referral received from:	Date of Referral: / /
Date of first contact: / /	Date of Assessment: / /
Email Address:	
Pension Card (type and number):	
Health Care Card (number and expiry date):	
DVA Card (colour and number):	
Medicare Number:	
Medicare Reference Number (number in front of name):	
Health Insurance (insurer and card number):	
General Practitioner:	
Specialist:	
NEXT OF KIN/CONTACT:	
Name:	Name:
Address:	Address:
Postcode:	Postcode:
Relationship:	Relationship:
Carer or Care Recipient?	
CARER:	
Name:	Co-Resident Carer:
Address:	☐ Yes ☐ No
Postcode:	
Telephone Number:	
Relationship:	
Current Living Arrangements:	
Primary Language:	Interpreter Required: ☐ Yes ☐ No
Cultural/Religious/Spiritual Needs:	
Country of Birth:	
Do you identify as Aboriginal or Torres Strait Islander? ☐ Yes ☐ No	
HEALTH HISTORY	
Current Diagnosis/Presenting Issues:	
Relevant Medical History:	
Relevant Surgical History:	

Do you have any skin pressure risks?	☐ Yes	☐ No	
If yes, please complete Braden Scale.			
Have you had any falls in the last 12 months?	☐ Yes	☐ No	
If yes, please complete Falls Risk Assessment.			
Pain: ☐ Yes ☐ No			
Site 1	Site 2	Front	Rear
Severity:	Severity:		
Intervention:	Intervention:		
Cognition:	☐ Nil Issues	Other:	
Mental Health:	☐ Nil Issues	Other:	
Chemist:			
Allergies (document allergy and reaction):			

CURRENT MEDICATIONS

Medication	Dose/Frequency	Route	Indication

Lifestyle:		
Do you drink alcohol?	☐ Yes ☐ No	Daily Intake:
Do you smoke?	☐ Yes ☐ No	Ceased: / /
Other Issues, e.g. Functional ADL's:		
Referrals Required:	☐ Yes ☐ No	Details:

DECLARATION

Name:	Designation:
Signature:	Date: