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?	☐ Yes ☐ No
If no, you will need to proceed to referral.	
Aboriginal or Torres Strait Islander?	☐ A ☐ TSI ☐ Both ☐ None
Interpreter required? ☐ Yes ☐ No	Preferred Language:
Medicare Number:	D.V.A. Number:
Telephone Number:	Mobile Number:
Carer Support Person? ☐ Yes ☐ 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?	☐ Yes ☐ 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

KOOWEERUP REGIONAL HEALTH SERVICE
DISTRICT NURSING SERVICE
ROSSITER ROAD, KOOWEERUP VIC 3981

SURNAME:	MAIDEN NAME (if applicable):	
GIVEN NAMES:	Married ☐Yes ☐No Single ☐Yes ☐No	
☐ Divorced ☐ Separated ☐ Other		
Gender I.D. ☐ Male ☐ Female ☐ Other		
FULL ADDRESS:		
POSTCODE:		
TELEPHONE NO. AH:	TELEPHONE NO. BH:	
EMAIL ADDRESS:		
BIRTH DATE: / /	AGE LAST BIRTHDAY:	
COUNTRY OF BIRTH: (Which State if born in Australia)	RELIGION:	
SPIRITUAL I.D.:	CULTURAL I.D.:	
DO YOU IDENTIFY AS INDIGENOUS? ☐ YES ☐ NO	Preferred Language:	Interpreter Required: Language:_____ ☐ Yes ☐ No
DO YOU IDENTIFY AS GLBTI ☐ YES ☐ NO		
HAVE YOU PREVIOUSLY BEEN A PATIENT IN THIS HOSPITAL? IF SO, APPROXIMATELY HOW LONG AGO .....? YES [ ] NO [ ]		
NEXT OF KIN'S NAME:	RELATIONSHIP:	
NEXT OF KIN'S TELEPHONE NUMBER:		
G.P.'s NAME:	G.P.'s PHONE NUMBER:	
PENSION NUMBER:	HEALTHCARE CARD NO:	
MEDICARE NUMBER (Please ensure you provide position number on the card): [ ][ ][ ][ ] [ ][ ][ ][ ][ ] [ ] Position No. [ ]		
ARE YOU PRIVATELY INSURED? YES [ ] NO [ ]		
IF YES, HEALTH FUND NAME:		
HEALTH FUND MEMBERSHIP NO:		
HEALTH FUND SCHEDULE:		
IS YOUR HOSPITALISATION, AS A RESULT OF ANY OF THE FOLLOWING? (Please circle, if appropriate)		
WORKCARE	MOTOR CAR ACCIDENT	VETERANS AFFAIRS
Claim No.	T.A.C. No.	Card Number:

Kooweerup Regional Health Service
P.O. Box 53, (Rossiter Road),
Kooweerup Vic 3981
Telephone: 59 979 679
Facsimile: 59 971 248

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	☐ Low ☐ Medium ☐High	Action Required ☐Yes ☐No
Braden Scale	☐LR ☐ AR ☐MR ☐HR ☐VHR	Action Required ☐Yes ☐No
Nutritional Risk	☐Yes ☐No	Action Required ☐Yes ☐No
Client Risk	☐Heat ☐Fire ☐Flood ☐Vulnerable	Added to Register ☐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**

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:	☐ YES ☐ NO	NAME:	
FAMILY/CARER	☐ YES ☐ NO	NAME/S:	CLIENT CONSENT: ☐ YES ☐ NO
OTHER STAFF:	☐ YES ☐ NO	NAME/S:	CLIENT CONSENT: ☐ YES ☐ NO
OTHER SERVICES:	☐ YES ☐ NO	NAME/S:	CLIENT CONSENT: ☐ YES ☐ NO

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

CLIENT/CARER SIGNATURE:
CLIENT/CARER NAME:
DATE: / /

STAFF SIGNATURE:
STAFF MEMBER'S NAME:
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

Located under Policies and Procedures/Forms Implemented: August 2018 Reviewed: November 2018

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

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.