dacs
DEMENTIA & AGED CARE SERVICES

# HCP Client Review Form

| Name: | DOB: |
|---|---|
| Address: | |
| Phone Home: | Phone Mobile: |
| AC Number: | Review: ☐ 6 Month ☐ 12 Month |

**Conduct a review of documents on file**
- check to ensure all documents are signed and dated.

| | | | |
|---|---|---|---|
| ☐ | HCP Service Agreement | ☐ | Charter of Aged Care Rights |
| ☐ | Consent to Collect Information | ☐ | Home Safety Checklist |
| ☐ | Direct Debit Request Form | ☐ | EG/EPOA (if applicable) |
| ☐ | Care Plan | ☐ | Admission Checklist |
| ☐ | Lifestyle Assessment | ☐ | Budget Planner |
| ☐ | Non Response Plan | | |

**Comments:**

**Conduct a review of client information recorded in HCM**
- check to ensure all applicable fields have been populated.

**Client General Details**

| | | | |
|---|---|---|---|
| ☐ | Client Name *(including preferred name if appliable)* | ☐ | Gender *(male, female, transgender, unknown)* |
| ☐ | Address<br>- *no commas are to be populated in address*<br>- *ensure the address has been pinpointed* | ☐ | Category *(CHSP, CHSP waitlist, HCP+level, Funded, Brokered)* |
| ☐ | Group *(correct region allocated)* | ☐ | First Registered Date *(date referral accepted)* |
| ☐ | Alerts (if required) | ☐ | Phone |
| ☐ | Email | ☐ | Date of Birth |
| ☐ | Medicare Number: | ☐ | Account Number<br>- *first 5 letters of surname = 40*<br>- *check if additional clients with same last name, numbering then 41, 42 etc.* |
| ☐ | AC Number | ☐ | Ethnic Origin |
| ☐ | Language/s | ☐ | Priority Rating |

**Comments:**

| **Attributes/Preferences Tab** | | | |
|---|---|---|---|
| ☐ | Smoker | ☐ | Dogs |
| ☐ | Dementia (suspected/diagnosis) | ☐ | Other |
| ☐ | Influenza Vaccine | ☐ | COVID-19 Vaccine |
| **Comments:** | | | |

**Client Contacts Tab**
- check contacts are current and still relevant. Remove and update at client request
- all clients to have minimum 1 contact listed
- ensure details are correct name, address, phone & email

| | | | |
|---|---|---|---|
| ☐ | Carer | ☐ | Family member |
| ☐ | Emergency Contact | ☐ | GP |
| ☐ | Case Manager / Service Coordinator | | |
| **Comments:** | | | |

**Services in Place**
- Including brokered or external services

| Current Services | Day/Time | Allocated Staff Member |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

**Review of current service**

Recent admission to hospital? ☐ Yes ☐ No ☐ N/A
Incidents, near misses and feedback reviewed? ☐ Yes ☐ No ☐ N/A

Outcomes:

Are identified needs being met?

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## Conduct a review of client History Notes

**Comments:**

- Ensure notes have been recorded and follow up has occurred where required.
- Have notes been added for last review completed?

## Review Client ACAT/MAC Referral Information

Does the client have any additional codes available? ☐ Yes ☐ No

Most recent MAC Support Plan uploaded to HCM ☐ Yes ☐ No

Ensure the following are uploaded in MAC:

| | | | |
|---|---|---|---|
| ☐ | Care Plan | ☐ | Note |
| ☐ | Budget | ☐ | Wallet Check |
| ☐ | Service Information | | |

## Client Care Plan:

Client Care Plan (DACSHCP-F-001) completed? ☐ Yes ☐ No
AQ - Mobile Care Plan ☐ Yes ☐ No

## Personal Care:

Hygiene Assessment (DACSHCP-F-136) completed? ☐ Yes ☐ No ☐ N/A
Skin Integrity Assessment (DACSHCP-F-125) completed? ☐ Yes ☐ No ☐ N/A

## Dental Care:

Oral Hygiene Assessment (DACSHCP-F-131) completed? ☐ Yes ☐ No ☐ N/A

Dentures? ☐ Yes ☐ No *If yes, please specify* ☐ Full ☐ Partial (Top) ☐ Partial (Bottom)

## Continence Support:

Ballarat Urinary Assessment (DACSHCP-F-133) completed? ☐ Yes ☐ No ☐ N/A
Ballarat Bowel Assessment (DACSHCP-F-134) completed? ☐ Yes ☐ No ☐ N/A

| **Mobility Status:** |
|---|
| Mobility Assessment (DACSHCP-F-139) completed? ☐ Yes ☐ No ☐ N/A |
| |
| **Falls History:** |
| Falls Risk Assessment - FRAT (DACSHCP-F-130) completed? ☐ Yes ☐ No ☐ N/A<br>Falls Risk Assessment – FROP (DACSHCP-F-056) completed? ☐ Yes ☐ No ☐ N/A |
| |
| Required equipment in place? ☐ Yes ☐ No |
| Referral/Referral code for OT assessment required? ☐ Yes ☐ No |
| **Pain Assessment:** |
| Abbey Pain Scale Assessment (DACSHCP-F-132) completed? ☐ Yes ☐ No ☐ N/A<br>Brief Pain Assessment (DACSHCP-F-122) completed? ☐ Yes ☐ No ☐ N/A<br>Body Diagram Assessment (DACSHCP-F-135) completed? ☐ Yes ☐ No ☐ N/A |
| |
| **Nutrition/Meal Preparation:** |
| Dietary Assessment (DACSHCP-F-126) completed? ☐ Yes ☐ No ☐ N/A<br>Mini Nutritional Assessment (DACSHCP-F-124) completed? ☐ Yes ☐ No ☐ N/A |
| Current Weight: |

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| **Wound Status:** | |
|---|---|
| Waterlow Assessment (DACSHCP-F-129) completed? ☐ Yes ☐ No ☐ N/A<br>Braden Risk Assessment (DACSHCP-F-123) completed? ☐ Yes ☐ No ☐ N/A | |
| | |
| **Cognitive Status:** | |
| Mini Mental State Examination MMSE completed? ☐ Yes ☐ No ☐ N/A | |
| | |
| **Medication Management/Pharmacy:** | |
| Client Medication Assessment (DACSHCP-F-127) completed? ☐ Yes ☐ No ☐ N/A<br>Current Medication List from GP? ☐ Yes ☐ No ☐ N/A<br>Dr Letter – Request for Clinical History (DACSHCP-F-094)? ☐ Yes ☐ No ☐ N/A<br>Recent Health summary ☐ Yes ☐ No ☐ N/A | |
| | |
| **Communication:** | |
| Communication/Sensory assessment (DACSHCP-F-140) completed? ☐ Yes ☐ No ☐ N/A | |
| Vision: | Hearing: |
| **Hazards:** | |
| Home Safety Checklist (DACSHCP-F-070) completed? ☐ Yes ☐ No ☐ N/A | |
| | |

| **Plan for Non-Response to a Scheduled Visit:** | | |
|---|---|---|
| | | |
| **Client Goals** | | |
| Goal | Outcome | Responsible |
| | | |
| | | |
| | | |

| ACAT reassessment required: ☐ Yes ☐ No | Date Completed: |
|---|---|
| Payment Option: ☐ Direct Debit ☐ Invoice | |
| **Review Summary/Additional Comments:** | |

| **Referrals required** |
|---|
| Are there referrals required? ☐ Yes ☐ No |
| *If yes, please outline what is required and what action has been taken*<br>☐ Allied Health ☐ Meals |

| Client Care Plan reviewed/updated? ☐ Yes ☐ No | Date: |
|---|---|
| Priority rating updated as outcome of review | ☐ Yes ☐ No |
| Updated documents uploaded to client profile in HCM? | ☐ Yes ☐ No |
| Date: | |
| Review history note added in HCM? | ☐ Yes ☐ No |
| Date: | |
| | |
| Client/Representative Name: | Date: |
| Signed: | |
| Review Completed by: | Date: |
| Role: | |
| Signed: | |
| Client Review form uploaded to HCM? | ☐ Yes ☐ No |
| Date: | |