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 - *no commas are to be populated in address* - *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 - *first 5 letters of surname = 40* - *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?

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 (HCP-F-001) completed? ☐ Yes ☐ No

AQ - Mobile Care Plan ☐ Yes ☐ No

Personal Care:

Hygiene Assessment (HCP-F-024) completed? ☐ Yes ☐ No ☐ N/A

Skin Integrity Assessment (HCP-F-007) completed? ☐ Yes ☐ No ☐ N/A

Dental Care:

Oral Hygiene Assessment (HCP-F-012) completed? ☐ Yes ☐ No ☐ N/A

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

Continence Support:

Ballarat Urinary Assessment (HCP-F-013) completed? ☐ Yes ☐ No ☐ N/A

Ballarat Bowel Assessment (HCP-F-014) completed? ☐ Yes ☐ No ☐ N/A

Mobility Status:
Mobility Assessment (HCP-F-027) completed? ☐ Yes ☐ No ☐ N/A
Falls History:
Falls Risk Assessment - FRAT (HCP-F-015) completed? ☐ Yes ☐ No ☐ N/A Falls Risk Assessment – FROP (HCP-F-096) 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 (HCP-F-006) completed? ☐ Yes ☐ No ☐ N/A Brief Pain Assessment (HCP-F-017) completed? ☐ Yes ☐ No ☐ N/A Body Diagram Assessment (HCP-F-005) completed? ☐ Yes ☐ No ☐ N/A
Nutrition/Meal Preparation:
Dietary Assessment (HCP-F-023) completed? ☐ Yes ☐ No ☐ N/A Mini Nutritional Assessment (HCP-F-011) completed? ☐ Yes ☐ No ☐ N/A
Current Weight:

Wound Status:
Waterlow Assessment (HCP-F-010) completed? ☐ Yes ☐ No ☐ N/A Braden Risk Assessment (HCP-F-009) completed? ☐ Yes ☐ No ☐ N/A
Cognitive Status:
Mini Mental State Examination MMSE completed? ☐ Yes ☐ No ☐ N/A
Medication Management/Pharmacy:
Client Medication Assessment (HCP-F-016) completed? ☐ Yes ☐ No ☐ N/A Current Medication List from GP? ☐ Yes ☐ No ☐ N/A Dr Letter – Request for Clinical History (HCP-F-094)? ☐ Yes ☐ No ☐ N/A Recent Health summary ☐ Yes ☐ No ☐ N/A
Communication:
Communication/Sensory assessment (HCP-F-026) completed? ☐ Yes ☐ No ☐ N/A

Vision:	Hearing:

Hazards:
Home Safety Checklist (HCP-F-032) 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 ☐ 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:		