CHSP CLIENT REVIEW FORM

Name:	DOB:
Address:	
Phone (Home):	Phone (Mobile):
AC Number:	Review: ☐ 6 Month ☐ 12 Month
Review to be completed by:	
☐ Home Visit ☐ Phone	Date: / Time:

Conduct a review of documents on file

- check to ensure all documents are signed and dated.
- follow up any allied health reports have been actioned.

☐	Client 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
☐	MAC Support Plan	☐	Health/Medication Summary (if applicable PC)
☐	Allied Health Reports (if applicable)	☐	Focus Assessments (if applicable)

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)*
☐	Group *(correct region allocated)*	☐	First Registered Date *(date referral accepted)*
☐	Status (active/inactive/finished)	☐	Alerts (if required)
☐	Phone	☐	Medicare Number
☐	Email *(request address if not noted)*	☐	Date of Birth
☐	AC Number	☐	Account Number - *first 5 letters of surname = 40* - *check if additional clients with same last name, numbering then 41, 42 etc.*
☐	Language/s	☐	Religion
☐	Ethnic Origin	☐	Priority Rating

Comments:

Attributes/Preferences Tab

☐	Smoker	☐	Dogs
☐	Dementia (suspected/diagnosis)	☐	Other
☐	COVID-19 Vaccination	☐	Flu Vaccination

Comments:

Client Contacts Tab

- **all clients to have minimum 1 contact and a GP listed**
- check details are current and correct name, address, phone & email are listed

☐	Carer	☐	Family member
☐	Emergency Contact	☐	GP

Comments:

DSS Tab

☐	Country of Birth	☐	Language
☐	Aboriginal/Torres Strait Islander	☐	Carer Availability
☐	Accommodation Type	☐	DVA Card Status
☐	Household composition	☐	Consent
☐	Disabilities: ☐ physical/diverse ☐ intellectual learning ☐ psychiatric ☐ sensory/speech ☐ not stated/inadequately described ☐ none		

Comments:

Services in Place

- Ensure fund source and MAC referral codes are active. If inactive contact NSW Service Manager to revoke.
- Check in service tasks are attached to visit(s)
- Ensure new service agreement is supplied if there has been a change or increase to services

Current Services	Day/Time	Allocated Staff Member	In Service Tasks

Comments:
Conduct a review of client History Notes - Ensure notes have been recorded and follow up has occurred where required
Comments:
Review Client MAC profile
Does the client have HCP approval? ☐ Yes ☐ No Ensure the category is updated to reflect CHSP – Waitlist HCP)
Does the client have any additional codes available? ☐ Yes ☐ No
Comments:
Review of current services/needs conducted with client
Current health conditions as reported by client:
Hospital Admissions in past 12 months?
Personal Care: Hygiene Assessment (DACSRES-F-136) completed? ☐ Yes ☐ No ☐ N/A Skin Integrity Assessment (DACSRES-F-125) completed? ☐ Yes ☐ No ☐ N/A

Dental Care: Oral Hygiene Assessment (DACSRES-F-131) completed? ☐ Yes ☐ No ☐ N/A
Dentures? ☐ Yes ☐ No *If yes, please specify* ☐ Full ☐ Partial (Top) ☐ Partial (Bottom)
Continence Support: Ballarat Urinary Assessment (DACSRES-F-133) completed? ☐ Yes ☐ No ☐ N/A Ballarat Bowel Assessment (DACSRES-F-134) completed? ☐ Yes ☐ No ☐ N/A
Mobility Status: Mobility Assessment (DACSRES-F-139) completed? ☐ Yes ☐ No ☐ N/A
Falls History: Falls Risk Assessment (FROP-COM DACSRES-F-144 or FRAT DACSRES-F-130) completed? ☐ Yes ☐ No ☐ N/A
Comments: Falls in past 6 months?
Required equipment in place? ☐ Yes ☐ No
Referral/Referral code for OT assessment required? ☐ Yes ☐ No
Nutrition/Meal Preparation: Dietary Assessment (DACSRES-F-126) completed? ☐ Yes ☐ No ☐ N/A Mini Nutritional Assessment (DACSRES-F-124) completed? ☐ Yes ☐ No ☐ N/A
Current Weight:

Cognitive Status: PAS Assessment completed? ☐ Yes ☐ No ☐ N/A
Medication Management/Pharmacy: Client Medication Assessment (DACSRES-F-127) completed? ☐ Yes ☐ No ☐ N/A
Communication: Communication/Sensory assessment (DACSRES-F-140) completed? ☐ Yes ☐ No ☐ N/A

Vision:	Hearing:

Lifestyle & Activities: Lifestyle Assessment (DACSRES-F-121) completed? ☐ Yes ☐ No ☐ N/A
Hazards: Home Safety Checklist (DACSRES-F-070) completed? ☐ Yes ☐ No ☐ N/A

Domestic Tasks:
Transport and Community Access:
Family/Social Networks:
Plan for Non-Response to a Scheduled Visit:
Services in place meeting client needs? *(staff allocation, frequency etc).*

Client Goals		
Goal	Outcome	Responsible
Support Plan review required: ☐ Yes ☐ No	Date Completed:	

HCP discussion: ☐ Yes ☐ No

Provided brochure material for HCP/additional services: ☐ Yes ☐ No

Payment Option: ☐ Direct Debit ☐ Invoice

Additional Services Requested

- Service request emailed to Scheduling ☐ Yes ☐ No

Service/Task	Day	Time

Comments:

Additional Referrals required? ☐ Yes ☐ No

If yes, please outline what is required and what action has been taken

Review Summary/Additional Comments:

Fund Source Review Date Updated (12 months)? ☐ Yes ☐ No

Client Care Plan reviewed/updated? ☐ Yes ☐ No

Date:

Updated documents uploaded to client profile in HCM? ☐ Yes ☐ No

Date:	
CHSP Client Review Note added in HCM? ☐ Yes ☐ No	
Date:	
Abridged Care plan mobile assessment completed 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:	