Alzheimer's QUEENSLAND

HCP Client Care Plan

CLIENT DETAILS	
Full Name:	Preferred Name:
Date of Birth:	Gender: ☐ Male ☐ Female ☐ Other
Address:	
Phone Number:	Mobile Number:
Email:	
CLIENT REPRESENTATIVE DETAILS	
Full Name:	Relationship:
Address:	
Phone Number:	Mobile Number:
Email:	
CASE MANAGER DETAILS	
Case Manager Name:	Phone Number:
Home Care Package Level: ☐ Level 1 ☐ Level 2 ☐ Level 3 ☐ Level 4	
Date of Care Plan:	Review Date:
MEDICAL AND HEALTH NEEDS	
Doctor Name:	Practice Name:
Address:	
Phone Number:	Email:
Preferred Hospital:	
Chemist/Pharmacy:	
Phone Number:	
Medical Conditions/Diagnosis:	
Medications: ☐ Morning ☐ Noon ☐ Night	
Client Medication Assessment Completed: ☐ Yes ☐ No ☐ N/A	Date:
Completed by:	
Allergies	
Alerts	
Dignity of Risk	

IN THE EVENT OF AN EMERGENCY PLEASE CONTACT 000 FOLLOWED BY MY CONTACTS OUTLINED BELOW	
Contact One:	Contact Two:
Phone:	Phone:

PLAN FOR NON-RESPONSE TO A SCHEDULED VISIT

☐ Repeat Knocking ☐ Call Contacts Above ☐ Call Client

☐ Contact Police ☐ Contact Neighbour ☐ Access via Key Safe

☐ Other: Key Safe Code:

LIFESTYLE AND ACTIVITIES

Lifestyle Assessment? ☐ Yes ☐ No ☐ N/A	Date:
Completed by:	

Lifestyle Choices, Cultural and/or Religious Needs:

Hobbies & Interests:

Short Term Goals & Action by Service:

Long Term Goals & Action by Service:

COMPLEX HEALTH CARE NEEDS *(select all that apply)*

☐ Diabetes ☐ Pain ☐ Modified Diet

☐ Fragile Skin ☐ Respiratory Condition ☐ Heart Condition

☐ Complex Wound Care ☐ Other

Management Plan:

Hospital Admissions in past 12 months? ☐ Yes ☐ No *If yes, provide details below*			
Falls in past 6 months? ☐ Yes ☐ No *If yes, provide details below*			
FRAT Assessment Completed? ☐ Yes ☐ No ☐ N/A			Date:
Completed by:			
MOBILITY			
Mobility Assessment Completed? ☐ Yes ☐ No ☐ N/A			Date:
Completed by:			
☐ 4 Wheel Walker	☐ Walking Stick	☐ Wheelchair	
☐ Nil Walking Aids	☐ Independently Mobile	☐ Other	
If other, specify:			
Level of Assistance:			
Transfers:			
Stairs:			
Additional Comments:			
COGNITIVE STATUS			
PAS Assessment? ☐ Yes ☐ No ☐ N/A			Date:
Completed by:			
Confusion: ☐ Mild	☐ Moderate	☐ Severe	☐ Variable
Orientated: ☐ Person	☐ Place	☐ Date	☐ Time of Day
Memory Difficulties:	☐ Short Term	☐ Long Term	
Insight into Difficulties: ☐ Yes ☐ No			
Requires Additional Cognitive Assessment: ☐ Yes ☐ No			
EMOTIONAL AND PSYCHOSOCIAL *(select all that apply)*			
☐ Anxiety	☐ Aggression	☐ Delusion	
☐ Hoarding	☐ Sexually inappropriate behaviour	☐ Restlessness/Agitation	
☐ Hallucinations	☐ Refusal of care	☐ Wandering	
☐ Other, *please specify*			

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Behaviour/Triggers:
Management Plan:

PERSONAL CARE SUPPORT				
Hygiene Assessment?	☐ Yes	☐ No	☐ N/A	Date:
Completed by:				
Skin Integrity Assessment?	☐ Yes	☐ No	☐ N/A	Date:
Completed by:				

Showering – when showering I require someone to *(select which applies)*

☐ Assist ☐ Supervise ☐ Set-up ☐ Independent

Preferred Time: ☐ AM ☐ PM

Dressing – when dressing I require someone to *(select which applies)*

☐ Assist	☐ Supervise	☐ Set-up	☐ Independent
Please assist me to:	☐ Select/Change	☐ Put on/Take off	☐ Fasten (zips/clasps)

Comments:

Grooming – when attending to my personal grooming I require someone to *(select which applies)*

☐ Assist	☐ Supervise	☐ Set-up	☐ Independent
Please assist me to:	☐ Shave	☐ Style my hair	☐ Apply make-up

Comments:

CONTINENCE SUPPORT

When attending to my toileting needs, I require someone to *(select which applies)*

☐ Assist	☐ Supervise	☐ Set-up	☐ Independent
☐ Urinary Incontinence	☐ Bowel incontinence	☐ Toileting Program	
☐ Continence Aids (Pads)	☐ Catheter		

Comments:

NUTRITIONAL SUPPORT

Dietary Assessment? ☐ Yes ☐ No ☐ N/A	Date:
Completed by:	

When attending to my dietary needs, I require someone to *(select which applies)*

☐ Assist ☐ Supervise ☐ Set-up ☐ Independent

Likes:

Dislikes:

ORAL HYGIENE

Oral Hygiene Management Plan? ☐ Yes ☐ No ☐ N/A	Date:
Completed by:	

When attending to my oral hygiene needs, I require someone to *(select which applies)*

☐ Assist ☐ Supervise ☐ Set-up ☐ Independent

Dentures: ☐ Yes ☐ No If yes, please specify below

☐ Full Denture ☐ Partial - Top ☐ Partial - Bottom

Comments:

SENSORY LOSS

Vision:	☐ Normal	☐ Impaired	Glasses required:	☐ Yes	☐ No
Hearing:	☐ Normal	☐ Impaired	Hearing aids:	☐ Yes	☐ No

Comments:

COMMUNICATION		
Primary Language:		Other Language/s:
☐ Coherent/Clear	☐ Jumbled	☐ Reduced Content
☐ Word Finding Difficulty	☐ Converses with Others	☐ Able to Communicate Effectively
Able to communicate needs effectively?	☐ Yes	☐ No
☐ Follows conversations	☐ Follows simple/short instructions	☐ Comprehends written instructions
Comments:		

INSTRUMENTAL ACTIVITIES OF DAILY LIVING			
Cleaning:	☐ Dependent	☐ Assisted	☐ Independent
Cooking/Meal Preparation:	☐ Dependent	☐ Assisted	☐ Independent
Gardening:	☐ Dependent	☐ Assisted	☐ Independent
Laundry:	☐ Dependent	☐ Assisted	☐ Independent
Transportation:	☐ Dependent	☐ Assisted	☐ Independent
Shopping:	☐ Dependent	☐ Assisted	☐ Independent
Do you have a Disability Parking Permit?	☐ Yes	☐ No	☐ N/A
Do you have a Companion Card	☐ Yes	☐ No	☐ N/A
If no, would you like assistance to apply?	☐ Yes	☐ No	☐ N/A
Comments:			

PACKAGE PURCHASES:	
1. Item Purchased:	Date:
Purchased From (Supplier):	
Value: $	
Description:	
2. Item Purchased:	Date:
Purchased From (Supplier):	
Value: $	
Description:	
3. Item Purchased:	Date:
Purchased From (Supplier):	
Value: $	
Description:	

GOALS

Area of Concern	Interventions/Strategies to achieve	Person Responsible	Review of Goals

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REQUESTED SERVICES				
On the following day/s:	☐ Monday ☐ Friday	☐ Tuesday ☐ Saturday	☐ Wednesday	☐ Thursday
I would like assistance with:				
On the following day/s:	☐ Monday ☐ Friday	☐ Tuesday ☐ Saturday	☐ Wednesday ☐ Sunday	☐ Thursday
I would like assistance with:				
On the following day/s:	☐ Monday ☐ Friday	☐ Tuesday ☐ Saturday	☐ Wednesday ☐ Sunday	☐ Thursday
I would like assistance with:				
On the following day/s:	☐ Monday ☐ Friday	☐ Tuesday ☐ Saturday	☐ Wednesday ☐ Sunday	☐ Thursday
I would like assistance with:				
On the following day/s:	☐ Monday ☐ Friday	☐ Tuesday ☐ Saturday	☐ Wednesday ☐ Sunday	☐ Thursday
I would like assistance with:				

MY INVOLVMENT AND CONTROL						
I have full authority to make decisions:	☐ Yes	☐ No				
I require _____ to participate in making decisions.						
_____ as the appointed representative will make decisions.						
Budget supplied	☐ Yes	☐ No				
Enduring power of attorney	☐ Yes	☐ No	Copy received	☐ Yes	☐ No	
Enduring Guardianship	☐ Yes	☐ No	Copy received	☐ Yes	☐ No	
Advance Care Directive	☐ Yes	☐ No	Copy received	☐ Yes	☐ No	
I would like the following people present at my review:						

Name	Relationship
1.	
2.	
3.	

CARER PROFILE	
Name:	Relationship:
Carer Overview *(History, Roles, Social Activities, Interests, Social Support etc.)*	

Availability of informal support to support carer:	☐ Yes	☐ No
Are other services used to support carer/client?:	☐ Yes	☐ No
Is the care recipient's health deteriorating?:	☐ Yes	☐ No
Is the caring role sustainable?:	☐ Yes	☐ No
Are there other demands on the carer?:	☐ Yes	☐ No
Provide Details:		

I hereby acknowledge that I am a partner:

- who has choice and flexibility in the way care and services are provided to me, based on my assessed need, which will assist me to achieve my agreed goals documented in this Care Plan;
- who has an understanding of the role of my Case Manager/Coordinator and the services and support I will be receiving;
- that received information about how my care fees and costs are calculated as stated in my Home Care Agreement
- who has been involved in the creation of my budget and understand the costs associated with my package and that I will receive a written monthly statement of available funds and expenditure.

I hereby agree to:

- receive the services as negotiated in this Care Plan and acknowledge that it has been reviewed according to my needs;
- contributing to the administration of my package;
- consult with my Case Manager/Coordinator if changes need to be made to services and Care Plan.

ASSESSMENT COMPLETION	
Coordinator Name:	Date:
Coordinator Signature:	
Client Name:	Date:
Client Signature:	
Client Representative Name:	Date:
Client Representative Signature:	

Review One (1 month)	
Review Completed By:	Date:
Staff Signature:	Role:
Client Name:	Date:
Client Signature:	
Client Representative Name:	Date:
Client Representative Signature:	
Comments:	

Review Two (6 months)	
Review Completed By:	Date:
Staff Signature:	Role:
Client Name:	Date:
Client Signature:	
Client Representative Name:	Date:
Client Representative Signature:	
Comments:	