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.

☐	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

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)*
☐	Alerts (if required)	☐	Phone
☐	Email	☐	Date of Birth
☐	Medicare Number: Reference Number: Expiry Date:	☐	Account Number - *first 5 letters of surname = 40* - *check if additional clients with same last name, numbering then 41, 42 etc.*
☐	AC Number	☐	Pension Status/DVA
☐	Language/s	☐	Ethnic Origin

Comments:

Alzheimer's QUEENSLAND

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Attributes/Preferences Tab			
☐	Smoker	☐	Dogs
☐	Dementia (suspected/diagnosis)	☐	Other
Comments:			

Client Contacts Tab - all clients to have minimum 1 contact listed - ensure details are correct name, address, phone & email			
☐	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		
Current Services	Day/Time	Allocated Staff Member
Comments:		

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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

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

Comments:

Review of current services/needs

Current health conditions as reported by client:

Personal Care:

Hygiene Assessment (RES-F-100) completed? ☐ Yes ☐ No ☐ N/A

Dental Care:

Oral Hygiene Assessment (RES-F-017) completed? ☐ Yes ☐ No ☐ N/A

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

Continence Support:

Ballarat Urinary Assessment (RES-F-022) completed? ☐ Yes ☐ No ☐ N/A

Ballarat Bowel Assessment (RES-F-023) completed? ☐ Yes ☐ No ☐ N/A

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Mobility Status: Mobility Assessment (RES-F-110) completed? ☐ Yes ☐ No ☐ N/A
Falls History: Falls Risk Assessment (FRAT)(RES-F-016) completed? ☐ Yes ☐ No ☐ N/A
Required equipment in place? ☐ Yes ☐ No
Referral/Referral code for OT assessment required? ☐ Yes ☐ No
Nutrition/Meal Preparation: Dietary Assessment (RES-F-010) completed? ☐ Yes ☐ No ☐ N/A Mini Nutritional Assessment (RES-F-008) completed? ☐ Yes ☐ No ☐ N/A
Current Weight:
Cognitive Status: PAS Assessment completed? ☐ Yes ☐ No ☐ N/A
Medication Management/Pharmacy: Client Medication Assessment (RES-F-011) completed? ☐ Yes ☐ No ☐ N/A

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Communication: Communication/Sensory assessment (RES-F-109) completed? ☐ Yes ☐ No ☐ N/A	
Vision:	Hearing:
Lifestyle & Activities: Lifestyle Assessment (RES-F-024) completed? ☐ Yes ☐ No ☐ N/A	
Hazards: Home Safety Checklist (RES-F-070) completed? ☐ Yes ☐ No ☐ N/A	
Domestic Tasks:	
Transport and Community Access:	
Family/Social Networks:	

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Plan for Non-Response to a Scheduled Visit:			
Services in place meeting client needs? *(staff allocation, frequency etc).*			
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/Task	Day	Time

Comments:

Review Summary/Additional Comments:

Referrals required? ☐ Yes ☐ No

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

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Client Care Plan reviewed/updated?		☐ Yes	☐ No
Date:			
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:			