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| **PHYSIOTHERAPY/EXERCISE PHYSIOLOGY ASSESSMENT & CARE PLAN** | | | | | | | | |
| **Is this client actively receiving ANY other services from DACS?**  Yes - Allied Health Therapist is required to review client care plan in VisualCare, once VC care plan has been reviewed, AH therapist is to complete assessment | | | | | | | | |
| No - Allied Health Therapist is responsible for completing full Assessment/Care Plan | | | | | | | | |
| **Assessment** | | | | | | | | |
| Client Name: | | | | | | | | |
| Preferred Name: | | | | Date of Birth: | | | | |
| Address: | | | | | | | | |
| Phone: | | | | Mobile: | | | | |
| Religion: | | | | Gender:  Male  Female  Other | | | | |
| Email: | | | | | | | | |
| Informed Consent:  Yes  No | | | | | | | | |
| Date of Assessment: | | | | | Time of Assessment: | | | |
| People present for assessment: | | | | | | | | |
| Current History: | | | | | | | | |
| Past History: | | | | | | | | |
| Client Self-Reported Functional Limitations: | | | | | | | | |
| Related imageBody Chart: | | | | | | | | |
| **Special Questions** | | | | | | | | |
| Spinal cord / Cauda Equina signs: | | | | | | | Yes  No | |
| Unexplained weight loss / gain: | | | | | | | Yes  No | |
| Deep Breath / Cough / Sneeze: | | | | | | | Yes  No | |
| Headaches: | | | | | | | Yes  No | |
| Dizziness / Diplopia / Dysarthria / Dysphagia / Drop attacks: | | | | | | | Yes  No | |
| Clicking / Locking / Giving Way / Instability: | | | | | | | Yes  No | |
| Pins & Needles / Numbness / Sharp shooting pain: | | | | | | | Yes  No | |
| Details (if any are yes): | | | | | | | | |
| Pain (24 hour behaviour, aggravators/eases): | | | | | | | | |
| Medications: | | | | | | | | |
| Social History (lifestyle / activities / sports / hobbies: | | | | | | | | |
| Typical exercise tolerance: | | | | | | | | |
| Stairs: | | | | | | | | |
| Falls history: | | | | | | | | |
| Services: | | | | | | | | |
| X-rays/Other investigations: | | | | | | | | |
| **Environment** | | | | | | | | |
| Stairs | Front: | | | | | Rail: | | |
| Internal: | | | | | Rail: | | |
| Rear: | | | | | Rail: | | |
| Details: | | | | | | | | |
| **Observation** | | | | | | | | |
| Joint ROM: | | | | | | | | |
| MMT: | | | | | | | | |
| Palpation: | | | | | | | | |
| Special Tests: | | | | | | | | |
| Sensation: | | | | | | | | |
| Hot / Cold: | | | | | | | | |
| Gait pattern: | | | | | | | | |
| Gait aid/s: | | | | | | | | |
| Timed Up and Go: | | | | | | | | |
| 30 sec STS or 5 x STS test: | | | | | | | | |
| Balance: | | Eyes open: | Feet together: | | | | | Feet apart: |
| Eyes closed: | Feet together: | | | | | Feet apart: |
| Tandem stance: | R) foot forward: | | | | | L) foot forward: |
| Other: | | | | | | | | |
| Goals: | | | | | | | | |
| Treatment plan: | | | | | | | | |

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| Equipment recommendation: | | | | | | | |
| Plan: | | | | | | | |
| Clinician Name: | | | | | | | |
| Role: | | | | | | | |
| Signature: | | | | | | | |
| Date: | | | | | | | |
| **CARE PLAN** | | | | | | | |
| Client Name: | | | | | Preferred Name: | | |
| Date of Birth: | | | | | Religion: | | |
| **Client Representative Details** | | | | | | | |
| Full Name: | | | | | Relationship: | | |
| Address: | | | | | | | |
| Phone: | | | | | Mobile: | | |
| Email: | | | | | | | |
| **Treating Physiotherapist/Exercise Physiologist Details** | | | | | | | |
| Full Name: | | | | | Phone number: | | |
| ACAT:  Yes  No | | | | | MAC Referral Number: | | |
| Date of Care Plan: | | | | | Review Date: | | |
| **Medical Health Needs** | | | | | | | |
| Doctor Name: | | | | | Practice Name: | | |
| Address: | | | | | | | |
| Phone Number: | | | | | Email: | | |
| 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: | |
| **Communication** | | | | | | | |
| Primary Language: | | | | | Other Language: | | |
|  | Coherent/Clear | |  | Jumbled | |  | Reduced Content |
|  | Word Finding Difficulty | |  | Converses with Others | |  | Able to Communicate Effectively |
| Additional Comments: | | | | | | | |

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| **Mobility** | | | | | | | |
|  | 4 Wheel Walker |  | Walking Stick | |  | | Wheelchair |
|  | Nil Walking Aids |  | Independently Mobile | |  | | Other |
| If Other, please specify: | | | | | | | |
| **Assessment Completion** | | | | | | | |
| Physiotherapist/Exercise Physiologist Name: | | | | | | | |
| Date: | | | | | | | |
| Signature: | | | | | | | |
| Client Name: | | | | | | Date: | |
| Signature: | | | | | | | |
| Client Representative Name: | | | | | | Date: | |
| Client Representative Signature: | | | | | | | |
| **Review Schedule** | | | | | | | |
| Is a review required?  Yes  No | | | | Scheduled Review Date: | | | |
| Review Completed by: | | | | | | Date: | |
| Role: | | | | | | | |
| Signature: | | | | | | | |
| Comments: | | | | | | | |