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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: |