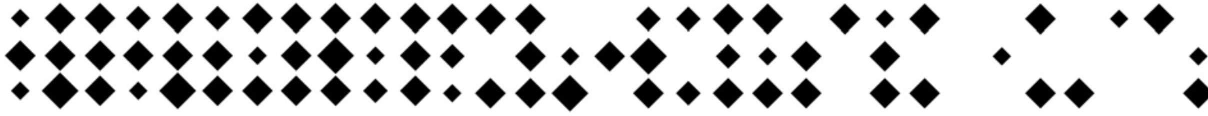


City of Charles Sturt

Home and Community Care Assessment and Referral

Client Information

Date:______/_____/_____

(Mr/Mrs/Ms) First Name: ____________________ Last Name: ____________________

Preferred Name: ____________________

Address: ____________________

Suburb: ____________________ Postcode: __________

Phone: ____________ Mobile: ____________ Email: ____________

☐ Male ☐ Female ☐ Unknown Age: ______ Date of Birth: ________ ☐ Estimate

Country of Birth: ________________ Language Spoken at Home: ________________

English Skills: ☐ Good ☐ Reasonable ☐ Limited ☐ Interpreter Required

Indigenous Status: ☐ Non Indigenous ☐ Aboriginal ☐ Torres Strait Islander ☐ Not Known

Referral Consent

Has client given verbal or written consent for the referral to Council of personal information? ☐ Yes ☐ No

Has client given verbal or written consent to allow future contact from the Community Care team including phone calls and written information? ☐ Yes ☐ No

Has client given permission to record personal information on the database and submit statistical data to DAC? ☐ Yes ☐ No

Has client been given verbal or written information on Rights, Responsibilities, Advocacy or Complaints? ☐ Yes ☐ No

Council Services Required

Cleaning: ☐ Short Term Cleaning *or* ☐ Spring Clean

Socialisation: ☐ Sages (Day Centre) *or* ☐ Henley Centre (Activities) *or* ☐ Neighbourhood Volunteer (Home Visitor)

Shopping: ☐ Community Bus *or* ☐ Assisted Shopping *or* ☐ Shopping List

Home Maintenance: ☐ Grab Rail Installation ☐ Security Assessment ☐ Gutter Clean

Details: ____________________

Client Information

Marital Status: ☐ Married, De Facto ☐ Divorced or Separated ☐ Widowed ☐ Never Married

Lives with: ☐ Alone ☐ Spouse/Partner ☐ Family Other ________

HACC Client Group: ☐ Frail Aged *or* ☐ Aged *or* ☐ Younger Disabled *or* ☐ Carer

Accommodation: ☐ Own Home ☐ SAHT ☐ Private Rental Other ________

Income Source: ☐ Aged Pension ☐ DVA ☐ Gold ☐ Blue ☐ White ☐ Private/Super ☐ Carer Allowance

☐ Carer Pension ☐ Disability Support Pension

Source of Referral

☐ Self ☐ Family ☐ Agency/Organisation: ________________

Name: *(Mr/Mrs/Ms)* ________________ Position: ________________

Phone: ____________ Mobile: ____________ Fax: ____________

Purpose of Referral: ☐ Recent Hospital Visit/Operation ☐ Loss of Carer ☐ Other

Details: ____________________

Relevant Medical History

Principle Diagnosis: ____

____

Proposed Discharge Date: ____________ Hospital: ______________________ ☐ Client is at Home

History: ☐ Osteoporosis ☐ Arthritis ☐ Poor Mobility ☐ Vision/Hearing Loss
☐ Incontinence ☐ Heart Condition ☐ Asthma ☐ Dementia

Details/Other: ____

Mobility Aides: ☐ Walking Stick – inside/outside ☐ Walking frame ☐ Wheelchair

Doctor: ____________________ Clinic: ______________________ Phone: ____________

Current Service Information

Indicate which services client is currently receiving or has been referred to:

ACAT:	☐ Current	☐ Referred	RDNS:	☐ Receiving	☐ Referred
CACP:	☐ Receiving	☐ Referred	Socialisation:	☐ Receiving	☐ Referred
HACC Package:	☐ Receiving	☐ Referred	Meals on Wheels:	☐ Receiving	☐ Referred
Metropolitan Dom Care:	☐ Receiving	☐ Referred	Access Cabs:	☐ Receiving	☐ Referred
Other:	☐ Receiving	☐ Referred			

Details: ____

____

OHW&S Issues

Does the client have pets? ☐ Yes ☐ No Comments: ______________________

Ambulance Cover? ☐ Yes ☐ No Comments: ______________________

Is client prone to falls? ☐ Yes ☐ No Comments: ______________________

Does the client have any behaviour issues (i.e. cognitive, personality, dementia)? ☐ Yes ☐ No

Details: ____

____

Are there any environmental safety concerns when providing services
(i.e. broken steps, abusive neighbour)? ☐ Yes ☐ No

Details: ____

____

Emergency Contacts

1 Contact: *(Mr/Mrs/Ms)*____

Relationship: __________ English Skills: ☐ Good ☐ Reasonable ☐ Limited ☐ Interpreter Required

Address: ____

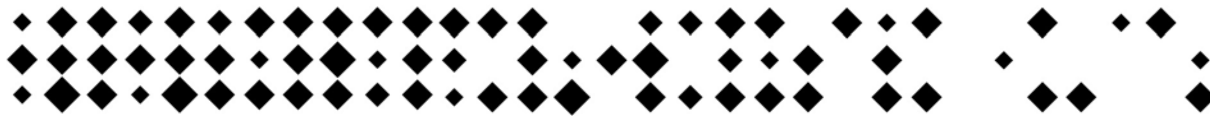
Phone: ______________ Work: ________________ Mobile: ______________________

2 Contact: *(Mr/Mrs/Ms)* ____

Relationship: __________ English Skills: ☐ Good ☐ Reasonable ☐ Limited ☐ Interpreter Required

Address: ____

Phone: ______________ Work: ________________ Mobile: ______________________



City of Charles Sturt

Home and Community Care (HACC MDS V2)

Client Name: ______________________________

Carer Information

Does the client have a carer who receives a Carer Allowance or Pension: ☐ Yes (complete this section) ☐ No

Carer is Emergency Contact: ☐ Yes (complete **Additional Carer Information** below) ☐ No (complete both sections)

(Mr/Mrs/Ms) Carer Last Name: ______________________________

First Name: ____________________ Preferred Name: ____________________

Address: ______________________________

Suburb: ______________________________ Postcode: __________

Carer Phone: ____________ Work: ____________ Mobile: ____________

Relationship: ______________________________

Additional Carer Information

☐ Male ☐ Female ☐ Unknown Age: ________ Date of Birth: __________ ☐ Estimate

Country of Birth: ____________________ Language Spoken at Home: ____________________

English Skills: ☐ Good ☐ Reasonable ☐ Limited ☐ Interpreter Required

Indigenous Status: ☐ Non Indigenous ☐ Aboriginal ☐ Torres Strait Islander ☐ Not Known

☐ Carer lives with Client ☐ Does Not live with Client

Does Carer provide assistance for more than one person? ☐ Yes ☐ No

Carer Support? ☐ Carer Allowance ☐ Carer Pension ☐ None

Care Provided: ______________________________

Client Functionality

Ability to do housework:

☐ Are you completely unable to do housework?
☐ With some help (e.g. can do light housework but need help with heavy housework)?
☐ Are you able to do housework without help (e.g. mop/vacuum floors)?

Ability to get places further than walking distance:

☐ Are you completely unable to travel unless emergency arrangements are made for a specialised vehicle (e.g. ambulance)?
☐ Do you travel with some help (i.e. need someone to help you or go with you when travelling)?
☐ Are you able to travel without assistance (i.e. do you drive your own car, or travel alone on buses or in taxis)?

Ability to go shopping for groceries or clothes:

☐ Are you completely unable to go shopping?
☐ Do you go shopping with some help (e.g. someone goes with you on all shopping trips)?
☐ Are you able to take care of all shopping needs yourself without help?

Ability to take medication:

☐ Are you completely unable to take your own medicines?
☐ With some help (e.g. if someone else prepares it for you and/or reminds you to take it)?
☐ Can you take your own medication without any help (i.e. the right dose at the right time)?

Ability to handle own money:

- ☐ Are you completely unable to handle money?
- ☐ Are you able to handle you money with some help (e.g. are able to manage day to day shopping but need help with managing bill paying, chequebook and account maintenance)?
- ☐ Are you able to handle all your financial transactions (e.g. write cheques, pay bills, banking, etc.)?

Ability to walk:

- ☐ Are you completely unable to walk?
- ☐ Are you able to walk with some help from a person or with the use of a walker, or crutches etc.?
- ☐ Are you able to walk without help (except for a cane or similar)?

Ability to bathe/shower:

- ☐ Are you completely unable to bathe?
- ☐ Do you require some assistance to bathe (e.g. getting into or out of the tub)?
- ☐ Are you able to bathe without help?

Does the client have memory problems/confusion?

- ☐ Yes
- ☐ No

Does the client have behavioural problems?

- ☐ Yes
- ☐ No

Does the client need help to communicate?

- ☐ No
- ☐ Yes, sometimes
- ☐ Yes, always

Additional Functionality (complete for High Level clients)

Ability to dress themselves:

- ☐ Are you completely unable to dress yourself?
- ☐ Are you able to dress with some help?
- ☐ Are you able to dress without help?

Ability to eat:

- ☐ Are you completely unable to eat without help?
- ☐ Are you able to eat with some assistance?
- ☐ Are you able to eat without help?

Ability to go to the toilet:

- ☐ Are you completely unable to manage the toilet without help?
- ☐ Are you able to go to the toilet with some assistance?
- ☐ Are you able to go to the toilet without help?

Does the client need help to get out of bed/move around?

- ☐ No
- ☐ Yes, sometimes
- ☐ Yes, always

Additional Comments? ____

____

____