

Date:

Completing The Form		
<input type="checkbox"/> Participant / Client	<input type="checkbox"/> Carer / Plan Nominee	<input type="checkbox"/> Case Manager
<input type="checkbox"/> General Practitioner (GP)	<input type="checkbox"/> NDIA / LACS	<input type="checkbox"/> Allied Health Specialist
<input type="checkbox"/> Other :		

The more information you can supply helps us understand your needs, but please only share what you feel comfortable with.

Participant Contact Details		
Number of Participants	<input type="checkbox"/> Only the One	<input type="checkbox"/> Family of
Name:		
DOB:		
Address:		
Phone #:		
Email:		
Preferred Contact	<input type="checkbox"/> Email	<input type="checkbox"/> Phone
Nominee (if applicable)		
Nominee Contact Details		

NDIS Plan & Priorities			
NDIS #			
Primary Diagnosis			
Referral By			
Purpose of Referral			
Current NDIS Plan	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Dates:
Plan Manager	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Details:
Support Coordinator (SC)	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Details:
	Reason for Changing Support Coordinator:		

Support Referral Type			
Service			
<input type="checkbox"/> Support Coordination (SC) & Specialist Support Coordination (SSC)			
<input type="checkbox"/> Understand the Plan <input type="checkbox"/> Insecure Housing <input type="checkbox"/> Community Support <input type="checkbox"/> Criminal Justice <input type="checkbox"/> Drug and Alcohol		<input type="checkbox"/> Develop Independence <input type="checkbox"/> Dual Diagnosis - Complex Disability <input type="checkbox"/> Complex Stakeholder Management <input type="checkbox"/> NDIS Plan Preparation <input type="checkbox"/> Guardianship	
Support Hours	<input type="checkbox"/> 0-30 <input type="checkbox"/> 30-60 <input type="checkbox"/> 60+	Support Budget	
<input type="checkbox"/> Behaviour Management Counselling (BMC)			
<input type="checkbox"/> Training		<input type="checkbox"/> Behaviour Support Plan	
<input type="checkbox"/> Behaviour Support Consulting – Charged to Improved Daily Living			
Support Hours	<input type="checkbox"/> 0-30 <input type="checkbox"/> 30-60 <input type="checkbox"/> 60+	Support Budget	
<input type="checkbox"/> Psychosocial Recovery Coaching (PRC)			
<input type="checkbox"/> Understand the Plan <input type="checkbox"/> Insecure Housing <input type="checkbox"/> Community Support <input type="checkbox"/> Criminal Justice <input type="checkbox"/> Drug and Alcohol <input type="checkbox"/> Peer Support (PRC)		<input type="checkbox"/> Develop Independence <input type="checkbox"/> Dual Diagnosis - Complex Disability <input type="checkbox"/> Complex Stakeholder Management <input type="checkbox"/> NDIS Plan Preparation <input type="checkbox"/> Guardianship	
Support Hours	<input type="checkbox"/> 0-30 <input type="checkbox"/> 30-60 <input type="checkbox"/> 60+	Support Budget	
<input type="checkbox"/> Rehabilitation Counselling (RC)			
<input type="checkbox"/> Vocational Assessment, Plan and Case Management <input type="checkbox"/> Educational Assessment, Plan and Case Management			
Support Hours	<input type="checkbox"/> 0-30 <input type="checkbox"/> 30-60 <input type="checkbox"/> 60+	Support Budget	

Please Attach Copy of Plan	
Attach Any Supporting Documentation	
Additional Notes	

Once completed, please forward to clientsupport@healthandcommunitysolutions.com.au with any supporting documentation.

Any additional questions please contact Jody via email jody@healthandcommunitysolutions.com.au.

HEALTH AND COMMUNITY SOLUTIONS PRIVACY POLICY

Confidentiality: Health & Community Solutions Team (voluntary & paid), are organisationally bound to respect the confidentiality of information obtained in the course of their professional service at all times.

Health & Community Solutions Team will not share information revealed by clients without explicit written client consent, except where legislation indicates.

All client files and records are the sole property of the service and will be managed in accordance with privacy legislative requirements.

Conflict of Interest: Health & Community Solutions Team (voluntary & paid) owe a duty to the organisation and its clients which requires avoidance of any perceived conflicts of interest, and to act at all times in the best interests of the organisation and its clients, while representing the organisation.

All actual and potential conflicts of interests are disclosed by Health & Community Solutions Team members through the annual disclosure form and/or whenever a conflict arises.

Choice & Control: Health and Community Solutions will at all times provide participants with a choice of Providers ensuring the match and fit of the Provider/Supports to the Participants satisfaction.

PARTICIPANT DETAILS			
NDIS #			
Name:			
DOB:			
Site Address:			
Phone #:			
HOME VISIT RISK ASSESSMENT			
Completed by (H&CS Team Member)			
Risk assessment completed with client / carer	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Dates:
Client / Carer has consented to the home visit	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Dates:
Type of Residence			
<input type="checkbox"/> House	<input type="checkbox"/> Unit	<input type="checkbox"/> Caravan Park	
<input type="checkbox"/> Aged Care Facility	<input type="checkbox"/> Department of Housing	<input type="checkbox"/> Other:	
Ensuring Access to Property and Client	No	Yes	If yes, please give details.
Are the street signs or property number hidden from view?	<input type="checkbox"/>	<input type="checkbox"/>	
Is the house hidden from the street?	<input type="checkbox"/>	<input type="checkbox"/>	
Is the gate difficult to open?	<input type="checkbox"/>	<input type="checkbox"/>	
Are there uneven/dangerous paths leading to the house?	<input type="checkbox"/>	<input type="checkbox"/>	
Does the client / carer have difficulty opening the door?	<input type="checkbox"/>	<input type="checkbox"/>	
Does the client need to have another person present?	<input type="checkbox"/>	<input type="checkbox"/>	
Does the client have any religious or cultural considerations? Eg. male / female clinician preference.	<input type="checkbox"/>	<input type="checkbox"/>	
Animals / Pets	No	Yes	If yes, please give details.
Any animals with open access to the front of the property or inside the house?	<input type="checkbox"/>	<input type="checkbox"/>	

HOME VISIT RISK ASSESSMENT			
Occupants	No	Yes	If yes, please give details.
Is it likely that any people in the house will be smoking or drinking alcohol during our visit?	<input type="checkbox"/>	<input type="checkbox"/>	
Is there known substance abuse amongst people who may be present?	<input type="checkbox"/>	<input type="checkbox"/>	
Does the client or other people in the home have a history of actual or threatened violence or aggressive behaviour?	<input type="checkbox"/>	<input type="checkbox"/>	
Hazards	No	Yes	If yes, please give details.
Are there any known weapons or guns in the house?	<input type="checkbox"/>	<input type="checkbox"/>	<i>Are they locked away?</i>
Remote area (>30 minutes from HCS Office)?	<input type="checkbox"/>	<input type="checkbox"/>	
Is there difficulty with mobile phone reception and/or working land line?	<input type="checkbox"/>	<input type="checkbox"/>	
Any additional hazards identified? Eg. seasonal bushfire risks, flooding	<input type="checkbox"/>	<input type="checkbox"/>	
OUTCOME	PLAN		
No risks identified	<input type="checkbox"/>	Proceed with single clinician home visit.	
Risks identified – discussed with manager or delegate. Detail of rationale, decisions and actions taken	<input type="checkbox"/>	Proceed with single clinician home visit.	
	<input type="checkbox"/>	Home visit to proceed with 2 or more clinicians.	
	<input type="checkbox"/>	Risk identified which preclude home visit as an option.	
Signature:	Name:		Date: