

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		
GP Contact Details:		

Client Preferences	
<input type="checkbox"/> Interpreter Required:	
<input type="checkbox"/> Communication Preferences (Auslan, Text, Email, Audio/Visual):	
<input type="checkbox"/> Male Worker	<input type="checkbox"/> Female Worker
<input type="checkbox"/> Other:	

NDIS Plan & Priorities	
NDIS #	
Primary Diagnosis	
Referral By	

NDIS Plan & Priorities			
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"/> Develop Independence	
	<input type="checkbox"/> Insecure Housing	<input type="checkbox"/> Dual Diagnosis - Complex Disability	
	<input type="checkbox"/> Community Support	<input type="checkbox"/> Complex Stakeholder Management	
	<input type="checkbox"/> Criminal Justice	<input type="checkbox"/> NDIS Plan Preparation	
	<input type="checkbox"/> Drug and Alcohol	<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"/>	Behavior Management Counselling (BMC)		
	<input type="checkbox"/> Training	<input type="checkbox"/> Behavior Support Plan	
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"/> Develop Independence	
	<input type="checkbox"/> Insecure Housing	<input type="checkbox"/> Dual Diagnosis - Complex Disability	
	<input type="checkbox"/> Community Support	<input type="checkbox"/> Complex Stakeholder Management	
	<input type="checkbox"/> Criminal Justice	<input type="checkbox"/> NDIS Plan Preparation	
	<input type="checkbox"/> Drug and Alcohol	<input type="checkbox"/> Guardianship	
	<input type="checkbox"/> Peer Support (PRC)		
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 & PRIVACY

As an NDIS Provider we collect information from you, and about you, when you deal with us.

Your privacy is always important to us.

We keep all your personal information safe in a Registered multi factor identification accessed Client Relationship Management (CRM) system - Halaxy, and only collect what we need.

We need to follow federal laws about what information we collect, in what format (Reports, Files, Audio/Visual), how we look at your personal information, how we use it, and give it to other people/Providers.

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

H&CS Team will not share client information 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 interest are disclosed by Health & Community Solutions Team members through the annual disclosure form and/or whenever a conflict arises.

If a Health and Community Solutions Practitioner provides a service to a Participant (SC, PRC, RC or BMC) the Practitioner cannot provide a secondary support to the Participant. Conflict of Interest must be declared and managed if two supports are provided by Health and Community Solutions.

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.

This is documented in Client files.

PARTICIPANT DETAILS			
NDIS #			
Name:			
DOB:			
Site Address:			
Phone #:			
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:
HOME VISIT			
Type of Residence			
<input type="checkbox"/> Supported Independent Living (SIL) Provider			
<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"/>	

Occupants	No	Yes	If yes, please give details.
Does the client live alone?	<input type="checkbox"/>	<input type="checkbox"/>	
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 H&CS 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"/>	
CLIENT RISKS			
Dysphagia	No	Yes	If yes, please give details.
Does the client express any discomfort or difficulty with eating and swallowing? <i>*Note: H&CS Team are not qualified to diagnose Dysphagia. Swallowing and eating information provided by Client or Representative.</i>	<input type="checkbox"/>	<input type="checkbox"/>	<i>Any indication of eating or swallowing difficulty - request the clients permission to report to their GP for investigation (document contact following and 'Flag' in Halaxy)</i>
GP Contact Details:	Phone:		
OUTCOME	PLAN		
No risks identified	<input type="checkbox"/>	Proceed with single Practitioner home visit.	
Risks identified – discussed with manager or delegate. Detail of rationale, decisions and actions taken	<input type="checkbox"/>	Proceed with single Practitioner home visit.	
	<input type="checkbox"/>	Home visit to proceed with 2 or more Practitioners.	
	<input type="checkbox"/>	Risk identified which preclude home visit as an option.	
GP Notified of Swallowing Difficulty	<input type="checkbox"/>	Dated and Documented in Halaxy File	
Signature:	Name:		Date: