

HEALTH ASSESSMENT

Aged 75+ Aboriginal & Torres Strait Islander 55+
(to be conducted by the patient's usual GP)

Practice Record

All
 Practice Home
 Item 700 Item 702

Aboriginal & Torres Strait Islander
 Practice Home
 Item 704 Item 706

PATIENT NAME _____

DOB _____

Name & contact
details of carer _____

Male / Female

Medical Practitioner

Medical record/file No. _____ / _____

Is this patient a carer? _____

Y / N

This is the only health assessment the patient
has undertaken in the last 12 months
This is a review of a Health Assessment
undertaken / / _____

Y / N

Health Assessment at Practice

Home Visit

CURRENT HEALTH / RELEVANT FAMILY HISTORY

1 **Ask the patient "in general, would you say your health is..."**

Excellent
 Very good
 Good
 Fair
 Poor

2 **Current health problems / relevant family history**

COMMUNITY / ALLIED HEALTH SERVICES

3 **Ask the patient "Are you seeing or have you seen any other GP/specialist/other health worker in the last 6 months?"**

- eg
- | | |
|--------------------------|--------------------|
| Aboriginal health worker | Orthoptist |
| Audiologist | Orthotist |
| Community nursing | Pharmacist |
| Continence Adviser | Physiotherapy |
| Daycare | Podiatry |
| Dental | Prosthetist |
| Dietician | Psychologist |
| Education providers | Registered nurse |
| HACC – home help | Respite care |
| Meals on wheels | Self help provider |
| Occupational therapist | Social worker |
| Optometrist | Specialist |
| | Speech therapist |

other services/specialists in last 6 months

reason

HEALTH ASSESSMENT

Aged 75+ Aboriginal & Torres Strait Islander 55+
(to be conducted by the patient's usual GP)

Practice Record

SMOKING / ALCOHOL

4 Smoking

- Never smoked
- Has quit smoking (when)
- Currently smokes
- Wishes to quit

Comments

5 Alcohol Consumption

Comments

Consider AUDIT, CAGE or other scales Y / N

PHYSICAL ACTIVITY

- 6 Do you **exercise** at least 30 minutes a day, most days Y / N

EXAMINATION

7 Weight

_____ kg

8

_____ m

9 BMI

10 BP/Pulses

Systolic BP _____ mm/Hg

Diastolic BP _____ mm/Hg

Pulse regular

Pulse irregular

Pulse rate _____

Comments

Consider check for postural hypotension Y / N

GENERAL PHYSICAL EXAMINATION

11 Comments

OTHER RELEVANT PHYSICAL EXAMINATION

12 Oral Health

Comments eg teeth, gums, dentures

13 Feet

Problems with one or both feet? Y / N

Comments

14 Vision

Acuity (with glasses)

Comments

15 Hearing

a Whisper test

Heard
Not heard

Comments

b Hearing aid

N/A
Adequate
Poor

c Check ear canals

Normal
Abnormal

16 Fit to drive

Comments

Y / N

Refer AustRoads Guidelines

HEALTH ASSESSMENT

Aged 75+ Aboriginal & Torres Strait Islander 55+
(to be conducted by the patient's usual GP)

Practice Record

NUTRITION

17 Nutrition

These questions may not apply to all eg those with particular conditions or lifestyles

- | | yes | no | score |
|--------------------------------------------------------------------------------------------------|-----|----|--------------------------|
| Do you have an illness or condition that made you change the kind and/or amount of food you eat? | 2 | 0 | <input type="checkbox"/> |
| Do you eat at least 3 meals per day? | 0 | 3 | <input type="checkbox"/> |
| Do you eat fruit or vegetables most days? | 0 | 2 | <input type="checkbox"/> |
| Do you eat dairy products most days? | 0 | 2 | <input type="checkbox"/> |
| Do you have 3 or more glasses of beer, wine or spirits almost every day? | 3 | 0 | <input type="checkbox"/> |
| Do you have 6-8 cups of fluids most days? | 0 | 1 | <input type="checkbox"/> |
| Do you have teeth, mouth or swallowing problems that make it hard to eat? | 4 | 0 | <input type="checkbox"/> |
| Do you always have enough money to buy food? | 0 | 3 | <input type="checkbox"/> |
| Do you eat alone most of the time? | 2 | 0 | <input type="checkbox"/> |
| Do you take 3 or more prescribed or over the counter medicines every day? | 3 | 0 | <input type="checkbox"/> |
| Without wanting to, have you lost or gained 5kg in the last 6 months? | 2 | 0 | <input type="checkbox"/> |
| Are you always able to shop, cook and/or feed yourself? | 0 | 2 | <input type="checkbox"/> |

Total score

0-3 'good', 4-5 'moderate', 6-29 'high risk'

Comments

MENTAL STATUS

18 Any problems with memory, thinking, planning, motivation?

Consider Folstein, MMSE, AMT Y / N

INDEPENDENCE / SOCIAL SUPPORT

19 Are you living

- Alone
As a couple
With others

Comments

20 Social support

- a During the last 4 weeks... was someone available to help you if you needed and wanted help? For example if you:
- Felt very nervous, lonely or blue
 - Got sick and had to stay in bed
 - Needed someone to talk to
 - Needed help with daily chores
 - Needed help just taking care of yourself
- Yes as much as I wanted
Yes, quite a bit
Yes, some
Yes, a little
No, not at all
- b Does this person have a carer? Y / N
- c Are you responsible for the care of someone else? If yes: who/relationship Y / N
-
- d Consider Dukes Scale Y / N
- e Referral to Allied health required? Y / N

MOOD / SLEEP

21 Mood (affect)

- a During the last 4 weeks... How much have you been bothered by emotional problems such as feeling anxious, depressed, irritable or downhearted or blue?
- Not at all
Slightly
Moderately
Quite a bit
Extremely
- b Have you had any difficulty sleeping? Y / N
- Details:
-

Consider Geriatric Depression Scale Y / N

Comment

HEALTH ASSESSMENT

Aged 75+ Aboriginal & Torres Strait Islander 55+
(to be conducted by the patient's usual GP)

Practice Record

CONTINENCE

22 Contenance

Leaking urine? Never
Sometimes
Often

Is this related to coughing or sneezing? Y / N

Faecal soiling/change of bowel habit Never
Sometimes
Often

Comment

HOME SAFETY / HOME VISIT

*Consider home visit
(See Appendix for checklist)*

23 Home Safety

Can you get down to up from your lounge chair easily and safely? Y / N

Can you get in and out of bed easily and safely? Y / N

Can you switch on a light easily from your bed? Y / N

Can you get on an off the toilet easily and safely? Y / N

Are all loose mats and floor coverings securely fixed to the floor? Y / N

Do you use slip resistant mats or self-adhesive non slip strips in the bath/bathroom/shower recess? Y / N

Can you carry meals easily and safely from the kitchen to your dining area? Y / N

Are you able to grip and use utensils efficiently and safely? Y / N

Are the edges of the steps/stairs easily identifiable? Y / N

Actions Suggested eg fitting of hand rails, removal of hazards, improving access

FUNCTIONAL ACTIVITIES

24 Mobility

Can you get around without a mobility aid indoors? Y / N
 Outdoors? Y / N

Can you bath/shower easily and safely? Y / N

Can you bend, kneel and stoop easily and safely? Y / N

Can you walk 100 metres easily? Y / N

Can you go up and down access steps to your home or internal stairs easily and safely? Y / N

Can you easily keep your balance when you reach overhead? Y / N

Are your walkways inside and outside the house free of cords and clutter? Y / N

Is all the household lighting adequate for you to see clearly? Y / N

Have you been free of falls in the home in the past 3 months? Y / N

Actions suggested

MEDICATION REVIEW

25 Complete the separate Medication Review Sheet

Comment

RELEVANT PREVENTIVE CARE CHECKLIST

26 Vaccinations **date**

Influenza

Pneumococcus

Tetanus

Other

Comments

27 Other areas for examination and or follow up
eg Pap smears, weight bearing exercise

HEALTH ASSESSMENT Summary

Patient Summary

PATIENT NAME _____ DOB _____ Carer _____

HEALTH ASSESSMENT HISTORY

Is this the only health assessment the patient has undertaken in the last 12 months Y / N If so, by whom _____

Is patient eligible under Veterans' Affairs Y / N If yes, please ensure this form is available on request from DVA _____

GOALS OF PATIENT AND CARERS

CURRENT MEDICAL SITUATION (complete Medication Review sheet separately)

Principal diagnoses _____ Planned investigation, care, medication (including over the counter complementary and prescriptions from other doctors) _____

Other significant health problems

OTHER RECOMMENDATIONS

I believe that the patient would benefit from

Care Plan Y / N Case Conference Y / N Other service to be recommended _____

PATIENT'S AGREEMENT

I have agreed / my carer has agreed to this Health Assessment and understand the recommendations above.

Signed by Patient / Carer / verbal _____ date

Signed by GP _____ date

A review date has been set (recommend 12 months or 6 months if change in clinical condition) for

Date: _____ Medical Record/File No: _____
 Patient Name: _____

Medication Review Form	Medical Practitioner Medical Record No.
-------------------------------	--------------------------------------------

Medication History				Medication Problem/s	Plan of Action:	
Medication* (generic/brand name and strength)	Prescribed dose/ frequency (if prescribed)	Actual dose/ frequency/ method of use	Treatment goal (reason for medication)	Tick those that apply	Actions/instructions to patient eg: dose change, cease, new medication, medication counselling, compliance aids	
				<input type="checkbox"/> none <input type="checkbox"/> not aware of medication <input type="checkbox"/> continuing need <input type="checkbox"/> dose/frequency/ formulation <input type="checkbox"/> duplication <input type="checkbox"/> other _____	<input type="checkbox"/> contraindications <input type="checkbox"/> adverse effects <input type="checkbox"/> drug-interaction <input style="border: 1px solid red;" type="checkbox"/> serum levels/ biochemistry required <input type="checkbox"/> compliance	<input type="checkbox"/> No change <input type="checkbox"/> Action (comment below)
				<input type="checkbox"/> none <input type="checkbox"/> not aware of medication <input type="checkbox"/> continuing need <input type="checkbox"/> dose/frequency/ formulation <input type="checkbox"/> duplication <input type="checkbox"/> other _____	<input type="checkbox"/> contraindications <input type="checkbox"/> adverse effects <input type="checkbox"/> drug-interaction <input style="border: 1px solid red;" type="checkbox"/> serum levels/ biochemistry required <input type="checkbox"/> compliance	<input type="checkbox"/> No change <input type="checkbox"/> Action (comment below)
				<input type="checkbox"/> none <input type="checkbox"/> not aware of medication <input type="checkbox"/> continuing need <input type="checkbox"/> dose/frequency/ formulation <input type="checkbox"/> duplication <input type="checkbox"/> other _____	<input type="checkbox"/> contraindications <input type="checkbox"/> adverse effects <input type="checkbox"/> drug-interaction <input type="checkbox"/> serum levels/ biochemistry required <input type="checkbox"/> compliance	<input type="checkbox"/> No change <input type="checkbox"/> Action (comment below)
				<input type="checkbox"/> none <input type="checkbox"/> not aware of medication <input type="checkbox"/> continuing need <input type="checkbox"/> dose/frequency/ formulation <input type="checkbox"/> duplication <input type="checkbox"/> other _____	<input type="checkbox"/> contraindications <input type="checkbox"/> adverse effects <input type="checkbox"/> drug-interaction <input type="checkbox"/> serum levels/ biochemistry required <input type="checkbox"/> compliance	<input type="checkbox"/> No change <input type="checkbox"/> Action (comment below)

OTHER RECOMMENDATIONS:

* Including prescription, over the counter (non-prescription) and complementary medications.

CARE PLAN

for patients with multidisciplinary care needs
(to be conducted by patient's usual GP)

Use this page to discuss the benefits of a care plan with your patient and to obtain their consent

	GP prepares	Review	GP contributes
care plan	723 <input type="checkbox"/>	725 <input type="checkbox"/>	729 <input type="checkbox"/>
discharge care plan	722 <input type="checkbox"/>		728 <input type="checkbox"/>

PATIENT NAME

DOB

Male / Female

Name & contact details of carer

Interpreter required

Y / N

Medical Practitioner

Medical record/file No.

/ /

CARE PLAN HISTORY

Is there a current care plan in existence

Y / N

If so, by whom
Date

Is the patient eligible under Veterans' Affairs

Y / N

If yes, please ensure this form is available on request from DVA

problem list (COMPLETE MEDICATION REVIEW SHEET SEPARATELY IF APPROPRIATE)

Principal diagnoses (chronic conditions)

Needs expressed by patient and carer or GP
(medical, social, psychosocial)

HEALTH PROVIDERS / SERVICES

Current

Others likely to assist

AUTHORITY TO PROCEED WITH CARE PLAN

My GP has explained the purpose of the care plan and I give / my carer gives permission to prepare a care plan and discuss my medical history and diagnosis with the providers listed.

Note any medical or personal information patient wants withheld from others

I do / do not have any medical or other information I want withheld from other participants.

All participants to retain confidentiality.

I am aware that there is a fee for the preparation of this care plan and a Medicare rebate will be payable

Has a needs assessment (biopsychosocial) been completed?

Y / N

If no, appointment for needs assessment has been set for

Date
Time

/ /
:

CARE PLAN Summary

Summary of goals to
be given to patient
and all members of
care team

PATIENT NAME _____ DOB _____ Carer _____

OTHER CHECKS

	Completed and attached	Recommended	Provider	Date
Case conference	<input type="checkbox"/>	<input type="checkbox"/>		
Medication review	<input type="checkbox"/>	<input type="checkbox"/>		
Other	<input type="checkbox"/>	<input type="checkbox"/>		

GOALS OF PATIENT AND CARERS

This section is for you to summarise the care plan for distribution to patient/carer and all members of care team

PATIENT'S AGREEMENT

I have agreed / my carer has agreed to this care plan and I understand the recommendations.

Signed by Patient / Carer / or Verbal _____ date _____

Signed by GP _____ date _____

Surgery Address, Phone Number _____

I would / would not like a reminder for my care plan assessment in _____ months time.

A review date has been set

Recommend 3 months after care plan

1 month after a discharge care plan organised by GP

6 months if GP is contributing

review date _____

CASE CONFERENCE

for patients with multidisciplinary care needs
(to be conducted by patient's usual GP)

Use this page to discuss the benefits of a case conference with your patient and to obtain consent

	15-29mins	30-44mins	>45mins	
case conference Items	740 <input type="checkbox"/>	742 <input type="checkbox"/>	744 <input type="checkbox"/>	GP prepares & coordinates
	759 <input type="checkbox"/>	763 <input type="checkbox"/>	765 <input type="checkbox"/>	GP contributes
discharge case conference Items	746 <input type="checkbox"/>	749 <input type="checkbox"/>	757 <input type="checkbox"/>	GP prepares & coordinates
	768 <input type="checkbox"/>	771 <input type="checkbox"/>	773 <input type="checkbox"/>	GP contributes

PATIENT NAME _____

DOB _____ Male / Female

Name & contact details of carer _____

Interpreter required ? Y / N _____

Medical Practitioner

Medical record/file No. _____ / _____ / _____

CASE CONFERENCE HISTORY

Has this patient had a case conference before Y / N If yes, by whom _____
Result _____

Is the patient eligible under Veterans' Affairs Y / N If yes, please ensure this form is available on request from DVA

problem list (COMPLETE MEDICATION REVIEW SHEET SEPARATELY IF APPROPRIATE)

Principal diagnoses (chronic conditions)	Needs expressed by patient and carer or GP (medical, social, psychosocial)
------------------------------------------	----------------------------------------------------------------------------

HEALTH PROVIDERS / SERVICES

Current	Others likely to assist
---------	-------------------------

AUTHORITY TO PROCEED WITH case conference

My GP has explained the purpose of the case conference and I give / my carer gives permission to prepare a case conference and discuss my medical history and diagnosis with the providers listed.	Note any medical or personal information patient wants withheld from others
----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-----------------------------------------------------------------------------

I do / do not have any medical or other information I want withheld from other participants.

All participants to retain confidentiality.

I am aware that there is a fee for the preparation of this case conference and a Medicare rebate will be payable

Appointment for my GP to discuss outcomes of the case conference with me has been set for

Signature _____ *date* _____

Date _____ / _____ / _____ *time* _____ :

CASE CONFERENCE Summary

This page to be given to patient and other team members

PATIENT NAME _____ DOB _____ Carer _____

Patient is a carer for _____

Face to face Telephone conference Other _____
 Start Time _____ Finish Time _____ Date _____

Tele conferences can be arranged by phoning Telstra Conferlink 1800 011 080 or Confertel 1800 505 075

HEALTH CARE PROVIDERS ON THIS TEAM

Care provider	Type of care	Contact No.	Report	
			Summary	Full
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>

* Provider responsible for distributing report after patient has given permission

MULTIDISCIPLINARY NEEDS

Need	Goal	Task	Provider	Review Date
				/ /
				/ /
				/ /
				/ /
				/ /
				/ /
				/ /

other checks

	Completed	Recommended	Provider	Date
Care plan	<input type="checkbox"/>	<input type="checkbox"/>		
Medication review	<input type="checkbox"/>	<input type="checkbox"/>		
Other _____	<input type="checkbox"/>	<input type="checkbox"/>		

PATIENT'S AGREEMENT

I have agreed / my carer has agreed to the goals and tasks arising from this case conference and I understand the recommendations.

Signed by Patient / Carer / or Verbal _____ date

Signed by GP _____ date

_____ surgery address, phone number