HACCPYP Intake FORM

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| Date: Click or tap to enter a date.  | [ ]  New Client [ ]  Existing client & Client # (if known): Click or tap here to enter text. |
| **Eligibility criteria (All four must be applicable):**[ ]  Under 65yo (or under 50yo for Aboriginal & Torres Straight Islanders)[ ]  Lives in City of Whittlesea (if in suburbs Bundoora, Yan Yean, Humevale & Beverage – check council area)[ ]  Living with a disability, mental health condition or a chronic health condition that is impacting on their ability to manage daily activities.[ ]  Not an NDIS participant |

# record of consent

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| City of Whittlesea collects and uses personal information to provide services to people. We are committed to the responsible handling of person, health, and sensitive information in accordance with our Information Sharing and Handling Business Rules. With this form we seek permission before sharing personal, sensitive or health related information. You can remove your consent at any time by contacting City of Whittlesea on (03) 9217 2170, press 5 to speak to a Customer Service Officer, then ask to be connected to the HACC PYP team.Please read the privacy statement by following the link for further information before consenting to share: [Consumer privacy information brochure - English version (health.vic.gov.au)](https://www.health.vic.gov.au/publications/consumer-privacy-information-brochure-english-version)  |
| You are agreeing to share the below information with:**City of Whittlesea****External agencies (as required)****Client emergency contacts (as required)** |
| Verbal consent? [ ]  No [ ]  Yes*I have discussed with the consumer how and why certain information may be shared with other service providers. I am satisfied that this has been understood and that informed consent for the information to be shared as detailed above has been given.* |
| Written consent? [ ]  No [ ]  Yes Signed: Date: Click or tap to enter a date.*The worker/practitioner has discussed with me how and why certain information about me may be shared with other service providers, as above. I understand this and I give my consent for the information to be shared.*  |

# Referrer Details

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| Self – referral: [ ]  Yes - Move to next section “Client Details” [ ]  No - If no please complete referral details below |
| How did you hear about us? Click or tap here to enter text. |
| Name:Click or tap here to enter text. |
| Relationship/role:Click or tap here to enter text. |
| Organisation:Click or tap here to enter text. |
| Phone number: Click or tap here to enter text. | Mobile Number:Click or tap here to enter text. |
| Email:Click or tap here to enter text. |

# Client Details

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| Given name:Click or tap here to enter text. | Family name: Click or tap here to enter text. |
| Title:Click or tap here to enter text. | Preferred name:Click or tap here to enter text. |
| Date of birth:Click or tap here to enter text. | Gender: Click or tap here to enter text. |
| Address: Click or tap here to enter text. |
| Phone no: Click or tap here to enter text. | Mobile: Click or tap here to enter text. |
| Email:Click or tap here to enter text. |
| NDIS status: [ ] Applying [ ] Rejected [ ] Not applied [ ] Appealing Any details about NDIS application progress/rejection? Click or tap here to enter text. |
| Does the client or anyone in the house have any DVA, TAC, work cover or NDIS funded services? **:**Click or tap here to enter text. |
| Income Source: [ ] Disability Support Pension [ ]  Carer Pension [ ]  Carer Allowance [ ]  Self-funded [ ]  Newstart Allowance [ ]  OtherClick or tap here to enter text. |
| Country of Birth: Click or tap here to enter text. |
| Indigenous Status: [ ]  Aboriginal or Torres Strait Islander – Please specify: [ ] Neither [ ]  Other/prefer not to say: Click or tap here to enter text. |

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| Accessibility or communication needs: [ ]  Yes [ ]  NoIf yes please specify:  Click or tap here to enter text. |
| Preferred Language:Click or tap here to enter text.Interpreter needed for assessment? [ ]  Yes [ ]  NoIf yes please specify:  Click or tap here to enter text. |
| Refugee or Asylum Seeker? [ ]  Yes [ ]  NoIf yes please specify year of arrival:  Click or tap here to enter text. |
| Living arrangements: [ ] Alone [ ] Spouse/partner [ ] Other – please specify below:Name & age:Click or tap here to enter text. |
| Accommodation: [ ] Owner [ ] Family Owned [ ] Private rental [ ] Public Housing [ ] Retirement Village [ ]  Other – Please specify:Click or tap here to enter text. |
| **Client contacts:**  |
| Emergency contact:1. Full name: Click or tap here to enter text. Relationship: Click or tap here to enter text. Phone: Click or tap here to enter text. Address: Click or tap here to enter text.2. Full name: Click or tap here to enter text. Relationship:Click or tap here to enter text. Phone: Click or tap here to enter text. Address: Click or tap here to enter text. |
| GP Details: Click or tap here to enter text. |
| **Carer details:** Carer [ ]  Yes [ ]  NoCarer name: Click or tap here to enter text. |
| Relationship: Click or tap here to enter text.DOB: Click or tap here to enter text. Residential status: Click or tap here to enter text.Address (if not same as client): Click or tap here to enter text. |
| Carer for another person: ☐Yes ☐No If yes, please provide further details: Click or tap here to enter text.  |
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# Reason for referral:

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| Recent hospital admission [ ] Yes [ ] No Discharge date: Click or tap to enter a date.Reason: Click or tap here to enter text.Post Acute Care end date (if relevant): Click or tap here to enter text. |
| **Reason for referral (ie Showering, Meals, In Home Care, Cleaning, Garden Maintenance, Medical Transport, hand rails):**Click or tap here to enter text. |
| **Presenting issues (ie why client needs service, who they live with & why they cannot assist):**Click or tap here to enter text. |
| **Significant history (ie medical/physical or mental health conditions, wellbeing, any safety concerns, family violence, housing issues):**Click or tap here to enter text. |

# Activities of Daily Living

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| **Is the client / are you able to:**  | **Comments (only comment if client has or you have stated there is difficulty or needs support)** |
| Walk easily?  | Click or tap here to enter text. |
| Get out of bed or chairs easily? | Click or tap here to enter text. |
| Shower or have a bath? (including drying & getting dressed) | Click or tap here to enter text. |
| Go to the toilet? | Click or tap here to enter text. |
| Prepare their own meals?  | Click or tap here to enter text. |
|  Eat meals? | Click or tap here to enter text. |
| Manage their own medication? | Click or tap here to enter text. |
| Travel in the community?  | Click or tap here to enter text. |
| Go shopping for groceries? | Click or tap here to enter text. |
|  Do housework? | Click or tap here to enter text. |
| Home or Garden maintenance? | Click or tap here to enter text. |
|  Manage their money? | Click or tap here to enter text. |

# Next step may be an onsite assessment. Prior to the assessment, please consider:

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| Will there be other people in the home during the assessment? [ ] Yes [ ] No[ ]  Yes [ ]  NoIf yes please specify who:  Click or tap here to enter text.  |
| Will these people be active participants in the assessment? [ ] Yes [ ] No Do you have concerns about involvement of these people in your assessment? [ ] Yes [ ] No  |
| Are you aware of any safety risks in the home? (i.e. clutter, smoking inside, pets, drug use, weapons): [ ]  Yes [ ]  NoIf yes please specify:  Click or tap here to enter text.  |