Agency _____

Record Unique Record Number

__ __ __ __ __ __ __ __ __ __ __ __

or affix label here

Title (please circle) Mr Mrs Ms Other ____

Family Name:

_____

Given Names:

_____

Preferred Name/s:

_____

Sex (please circle) 1. Male 2. Female

Date of birth *dd/mm/yyyy* _____ / _____ / _____

Contact details

Usual Address

_____ (number & street)

_____ (locality & postcode)

Contact Address (if different from usual address)

_____ (number & street)

_____ (locality & postcode)

Contact phone number/s (tick preferred number)	Can leave message? Y or N
Home	
Work	
Mobile	
Fax	
Email address	

Comments (incl. directions or other relevant contact issues)

Who the agency can contact if necessary

(eg, case manager, next of kin, carer, guardian, enduring power of attorney, friend, emergency contact)

Person 1 Name
Contact details (number & street)
(locality & postcode)
Phone:
Relationship to client

Person 2 Name
Contact details (number & street)
(locality & postcode)
Phone:
Relationship to client

General Practitioner (if no GP, write NA)

Name
Contact details (number & street)
(locality & postcode)
Phone:
Fax:
Email:

Details of person completing this page

Name_____ Designation_____ Agency_____

Sign_____ Date_____ Contact number_____

If information needs updating, indicate below and record updated information on a new Contact Information form

This information has been updated ☐ Date: _____

Name: _____ Sign: _____

Service Entry Data Set

Agency _____

Record Unique Record Number

__ __ __ __ __ __ __ __ __ __ __ __

Date of birth *dd/mm/yyyy* _____/_____/_____

or affix label here

Source of Referral

Record: **(1)** Self.
(2) Family, significant other, friend.
(3) GP/medical practitioner – community based.
(4) Specialist aged or disability assess team/service (eg. ACAT).
(5) Comprehensive HACC assessment authority
(6) Community nursing service.
(7) Hospital (public).
(8) Psychiatric/mental health service or facility.
(9) Extended care/rehabilitation facility.
(10) Palliative care facility/hospice.
(11) Government residential aged care facility.
(12) Aboriginal health service.
(13) Carelink centre.
(14) Other community-based government medical/health service.
(15) Other government medical/health service.
(16) Other government community-based services agency.
(17) Hospital (private).
(18) Non government residential aged care facility.
(19) Other non government medical/health service.
(20) Other non government community-based service.
(21) Law enforcement agency.
(22) Other.

If not self-referred, has client given consent for referral?
☐ Y ☐ N

Source of Referral Contact Details (if not GP)

Country of Birth

Record: **(1)** Australia. **(2)** Other.

If other, specify_____

Indigenous Status

Y ☐ N ☐

If Yes, record:
(1) Aboriginal but not Torres Strait Islander origin
(2) Torres Strait Islander but not Aboriginal origin
(3) Both Aboriginal and Torres Strait Islander origin
(9) Not stated

Main Language Spoken at Home

Record: **(1)** English. **(2)** Other.

If other, specify_____

Interpreter Required

Record: **(1)** Interpreter not needed. **(2)** Interpreter needed

Preferred language, (if not spoken English) including sign language, & any required communication devices or special interpreter needs

Government Pensioner/Benefit Status

Record: **(1)** Aged Pension
(2) Veterans' Affairs Pension (complete DVA Card Status below)
(3) Disability Support Pension
(4) Carer Payment (pension)
(5) Unemployment related benefits
(6) Other gov pension or benefit . If so, specify: _____
(7) No gov pension or benefit

Pensioner Concession Card ☐ Y ☐ N

Pension/Benefit Card Number

Medicare Number

Health Care Card Number

Australian DVA Card Status

Record: **(1)** No DVA Card
(2) Yes – Gold Card
(3) Yes – White Card
(4) Yes - Other DVA Card. If so, specify: _____

DVA Card Number

Insurance Status

Tick all that apply:

(1)	None	
(2)	Private health insurance – basic cover only	
(3)	Private health insurance – including auxiliary cover for private dental and allied health services	
(4)	Motor vehicle accident insurance	
(5)	Workers compensation	
(6)	Other 3rd party	
(7)	Ambulance fund	

Health Insurer Name and Card Number

Details of person completing this page

Name_____ Designation_____ Agency_____

Sign_____ Date_____ Contact number_____

If information needs updating, indicate below and record updated information on a new Service Entry Data Set form

This information has been updated ☐ Date: _____

Name: _____ Sign: _____

Why the consumer is seeking services

Agency _____

Record Unique Record Number

__ __ __ __ __ __ __ __ __ __ __ __

Date of birth *dd/mm/yyyy* _____ / _____ / _____
or affix label here

Alerts (including any relevant comments on risk or urgency)

ONI Priority Rating: Record rating here if relevant profiles have been completed to indicate relative priority for service

	Description of problem or issue as identified by the consumer or referring agency	Action/s required
1		
2		
3		
4		

	Description of other issues as identified by the consumer or in the Ongoing Needs Identification process	
1		
2		
3		
4		
5		

ACTION REQUIRED: Code
(1) Service provision – see Action Plan
(2) Specialist assessment
(3) Comprehensive assessment
(4) Nil: Consumer ineligible for service.
(5) Nil: Referred elsewhere.
(6) Nil: Advice/information provided. No further action required.
(7) Nil: Consumer declines further referral or service.
(8) Nil: Consumer issue resolved. No further action required.
(9) Nil: Service not available. Place on wait list.
(10) Nil: Requested service not accessible (eg, due to long waiting time, inaccessible location).

Current services

Record services used in the last three months or on a recurring basis. If more than 8 services used, append an additional page

Service	Record contact details or other information as appropriate

Consider all health, community and support services, including (but not limited to) formal domestic and personal care arrangements, Alternate Therapists, Aged Care, Alcohol and drug, Community health, Counselling, Dental care, Disability, Emergency accommodation, Family planning, Home care, Hospital inpatient, Hospital outpatient, Hospital emergency, Maternal and child health, Medical (GP), Medical (specialist), Men's health, Mental health, Palliative care, Rehabilitation, Residential Aged Care, Respite care, Self help groups, Sexual health, Women's health, Youth services

Details of person completing this page

Name_____ Designation_____ Agency_____

Sign_____ Date_____ Contact number_____

If information needs updating, indicate below and record updated information on a new Summary and Action Plan form

This information has been updated ☐ Date: _____

Name: _____ Sign: _____

Action Plan

Agency _____

Record Unique Record Number

__ __ __ __ __ __ __ __ __ __ __ __

Date of birth *dd/mm/yyyy* _____ / _____ / _____

or affix label here

Is this person HACC eligible? ☐ Y ☐ N ☐ D/K

If so, reason for HACC client status:

Care Recipient ☐ Carer ☐

Is this person eligible for disability services? ☐ Y ☐ N ☐ D/K

Is this person eligible for other support services, (eg, DVA, NRC)? ☐ Y ☐ N **If yes, specify** _____

Functional Profile is completed and attached? ☐ Y ☐ N **Alternately, summarise Functional Profile below:**

Item 1	Item 2	Item 3	Item 4	Item 5	Item 6	Item 7	Item 8	Item 9	Total score

After completing the relevant optional profiles, finalise the Action Plan below.

Action Plan

Taking into account the reason/s that the consumer is seeking services and any other issues you and the consumer have subsequently identified, summarise the action required. If more than 7 actions are required, append an additional sheet.

To be referred to (use codes below):

Agency/health professional	For	Consumer Consent	Referral Method	Transport Method	Feedback required	Date	Review Date

Agency/health professional: If you will be continuing to see the client, include yourself in the list of agencies/professionals for referral
For: Record purpose of referral
Consumer Consent: Record **(1)** Yes, consumer consents to referral and to sharing of information **(2)** Yes, consumer consents to referral but not to sharing of information **(3)** No, consumer has not consented to this referral

Referral method: Record **(1)** this form faxed to agency **(2)** letter (copy on file) **(3)** electronic **(4)** verbal request – face to face or phone call **(5)** other (incl. refer to self)
Transport Method: Record **(1)** Staff travel – service is delivered in home **(2)** Staff travel - client too unwell to travel **(3)** Staff travel – client has no transport **(4)** Client travel – own car **(5)** Client travel – family/friends **(6)** Client travel – public transport or taxi **(7)** Client travel – walk **(8)** Community transport **(9)** Ambulance **(10)** Hitchhike **(11)** None
Feedback required: Record **(1)** to initial referral agency **(2)** to GP **(3)** to agency completing ONI **(4)** to carer/guardian **(5)** other
Date: Record date referral actually made. If no referral actually made, leave blank
Review Date: Record date when action should be reviewed. If no need for review, leave blank

I have discussed the proposed referral/s and use/s of their personal information with the consumer/carer. I am satisfied that the consumer/carer understands the proposed uses and disclosures of the information that has been provided, and has provided their informed consent to these.

☐ Y ☐ N

Details of person completing this page

Name_____ Designation_____ Agency_____

Sign_____ Date_____ Contact number_____

If information needs updating, indicate below and record updated information on a new Summary and Action Plan form

This information has been updated ☐ Date: _____

Name: _____ Sign: _____

Living Arrangements Profile

Agency _____

Record Unique Record Number

__ __ __ __ __ __ __ __ __ __ __ __

Date of birth *dd/mm/yyyy* _____ / _____ / _____

or affix label here

Living arrangements

Record: **(1)** Lives alone **(2)** Lives with family **(3)** Lives with others **(99)** Not stated/inadequately described

Comments on living arrangements, including family arrangements (consider issues such as stability of arrangements, number of people in household etc)

Accommodation

Record: **(1)** Private residence – owned/purchasing **(2)** Private residence – private rental **(3)** Private residence – public rental **(4)** Private residence – mobile home **(5)** Independent living unit within a retirement village **(6)** Boarding house/private hotel **(7)** Short term crisis, emergency or transitional accommodation facility **(8)** Domestic-scale supported living facility **(9)** Supported accommodation facility **(10)** Residential aged care facility **(11)** Psychiatric / mental health community care facility **(12)** Public place/temporary shelter **(13)** Private residence rented from Aboriginal Community **(14)** Temporary shelter within an Aboriginal Community **(19)** Other **(99)** Not stated / inadequately described

Comments on accommodation

Consider accommodation status above if home modifications are required

Employment Status

Record: **(1)** Employed/self employed **(2)** Sheltered **(3)** Child/Student **(4)** Home duties **(5)** Unemployed **(6)** Retired for age **(7)** Retired for disability **(8)** CDEP **(9)** Other

Comments on employment

Financial and legal profile

Mental Health Act status

Record **(1)** Involuntary **(2)** Forensic Order **(3)** N/A

Decision-making responsibility

Record: **(1)** Self **(2)** Enduring Power of Attorney **(3)** Guardian

Is the person capable of making their own decisions?

☐ Yes ☐ No ☐ Not sure

If 'not sure' or 'no', consider the need for assistance, need for cognitive assessment and the implications for consent.

Financial decisions

Record: **(1)** Self **(2)** Enduring Power of Attorney **(3)** Financial Manager **(4)** Parent or Guardian

Cost of living decisions

Because of limited income, has the consumer during the last month made any trade-offs among purchasing any of the following: prescribed medications, necessary medical care, adequate food, necessary home care, necessary transport?

☐ Yes ☐ No ☐ Not sure

If yes, discuss issues with consumer and consider need for counselling (eg, financial, gambling, drug or alcohol) and need for material support.

Comments on legal and financial issues. Consider all legal issues including current legal orders (eg, AVO)

Details of person completing this page

Summarise issues & arising action on pages 3 & 4 of the Core ONI

Name_____ Designation_____ Agency_____

Sign_____ Date_____ Contact number_____

If information needs updating, indicate below and record updated information on a new LAP

This information has been updated ☐ Date: _____

Name: _____ Sign: _____

Psychosocial Profile

Agency _____

Record Unique Record Number

__ __ __ __ __ __ __ __ __ __ __ __

Date of birth *dd/mm/yyyy* _____ / _____ / _____

or affix label here

Mental health and well being

In the past 4 weeks about how often did you feel...

K10 scale		Score
1	tired out for no good reason?	
2	nervous?	
3	so nervous that nothing could calm you down?	
4	hopeless?	
5	restless or fidgety?	
6	so restless you could not sit still?	
7	depressed?	
8	that everything was an effort?	
9	so sad that nothing could cheer you up?	
10	worthless?	

Score:

1 None of the time
2 A little of the time
3 Some of the time
4 Most of the time
5 All of the time

Total K-10 Score: _____

***Recommended action**: refer for primary care mental health assessment if total score is 16-29 and for a specialist mental health assessment if score is 30 or more.*

Have you had any difficulty sleeping? Y ☐ N ☐

Details:

Personal and social support

During the past 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 ☐ *Consider referral & Functional Profile*

No, not at all ☐

Comment on personal and social support, including opportunities

Family and personal relationships

Does this person generally make and/or keep up friendships? ☐

(1) Friendships made or kept up well
(2) Friendships made or kept up with slight difficulty
(3) Friendships made or kept up with considerable difficulty
(4) No friendships made or none kept up

Does this person generally have problems (eg, friction, avoidance) interacting/living with others? ☐

(1) No obvious problem
(2) Slight problems
(3) Moderate problems
(4) Extreme problems

Comments

Relationships with service providers

Does the consumer mistrust health and community service providers because of previous bad experiences?

Yes ☐ No ☐ Not sure ☐

Comments

Details of person completing this page Summarise issues & arising action on pages 3 & 4 of the Core ONI

Name_____ Designation_____ Agency_____

Sign_____ Date_____ Contact number_____

If information needs updating, indicate below and record updated information on a new PP

This information has been updated ☐ Date: _____

Name: _____ Sign: _____

Functional Profile (Activities of Daily Living)

Agency _____

Record Unique Record Number

__ __ __ __ __ __ __ __ __ __ __ __

Date of birth *dd/mm/yyyy* _____ / _____ / _____

or affix label here

Questions to ask the consumer (or the person who represents the consumer).
I would like to ask you about some of the activities of daily living, things that we all need to do as part of our daily lives. I would like to know if you can do these activities without any help at all, or if you need some help to do them, or if you can't do them at all. The questions refer to how you are managing at the moment.

Item	Question	Score	Record score
1	**Can you do housework...**		
	Without help (can clean floors etc)?	2	
	With some help (can do light housework but need help with heavy housework)?	1	
	Or are you completely unable to do housework?	0	
2	**Can you get to places out of walking distance...**		
	Without help (can drive your own car, or travel alone on buses or taxis)?	2	
	With some help (need someone to help you or go with you when travelling)?	1	
	Or are you completely unable to travel unless emergency arrangements are made for a specialised vehicle like an ambulance?	0	
3	**Can you go out for shopping for groceries or clothes (assuming you have transportation)...**		
	Without help (taking care of all shopping needs yourself)?	2	
	With some help (need someone to go with you on all shopping trips)?	1	
	Or are you completely unable to do any shopping?	0	
4	**Can you take your own medicine...**		
	Without help (in the right doses at the right time)?	2	
	With some help (able to take medication if someone prepares it for you and/or reminds you to take it)?	1	
	Or are you completely unable to take your own medicines?	0	
5	**Can you handle your own money...**		
	Without help (write cheques, pay bills etc)?	2	
	With some help (manage day-to-day buying but need help with managing your chequebook and paying your bills)?	1	
	Or are you completely unable to handle money?	0	
Do not ask the following 2 questions if the client scored 2 on all of the above 5 items (ie, can do all 5 activities without help). Instead, for clients who scored 2 on all of the above items, record a 9 on each of the following 2 items to indicate that you did not ask the question.			
6	**Can you walk...**		
	Without help (except for a cane or similar)?	2	
	With some help from a person	1	
	Or are you completely unable to walk?	0	
7	**Can you take a bath or shower...**		
	Without help?	2	
	With some help (eg, need help getting into or out of the bath)?	1	
	Or are you completely unable to bathe yourself?	0	

NOTES:

- If unanswered, score X.
- Rate what the person is **currently capable** of doing rather than what they actually do. In assessing capability, take into account not only physical function but also cognition (such as problems caused by dementia or an intellectual disability) and behaviour (such as unpredictable challenging behaviour). Consumers able to complete a task with verbal prompting should not be rated as independent (and therefore should be rated as a 1).
- In rating an item that is irrelevant (for example, the person has no shops in the vicinity or does not use any medications), rate based on what the person would be capable of doing if the item was actually relevant to their situation.
- Item 6 (walking). Clients who are in a wheelchair should be rated as (1) if they are independent including corners etc or (0) if they are not wheelchair independent.

Details of person completing this page Summarise issues & arising action on pages 3 & 4 of the Core ONI

Name_____ Designation_____ Agency_____

Sign_____ Date_____ Contact number_____

If information needs updating, indicate below and record updated information on a new FP

This information has been updated ☐ Date: _____

Name: _____ Sign: _____

Functional Profile (Activities of Daily Living)

Agency _____

Record Unique Record Number

__ __ __ __ __ __ __ __ __ __ __ __

Date of birth *dd/mm/yyyy* _____ / _____ / _____
or affix label here

Questions for you to complete

Complete the following based on all information available to you – your judgement based on interviewing or observing the client, information contained in a referral letter, consumer notes or information provided by a proxy respondent, such as a friend, relative, carer or referring agency.

Note that the consumer should not be directly asked to answer these questions

Item	Question	Record score
8	Does the person have any memory problems or get confused?	
	No – score 2	
	Yes – score 0	
9	Does the person have behavioural problems for example, aggression, wandering or agitation?	
	No – score 2	
	Yes – score 0	

Recommended functional assessments based on this functional profile (tick all that are recommended)

Domestic ☐

Look solely at items 1 to 5. Count the number of these items that scored 2 (ie, count the number of activities that the person can do without help). Refer for a domestic functional assessment if the person can do less than 3 activities without assistance – ie, the count is 2 or less (a count of 0, 1 or 2).

Self-care ☐

Refer for a self-care functional assessment if the consumer SCORED LESS THAN 2 on either Item 6 (mobility) or Item 7 (bathing).

Cognition ☐

Refer for a cognitive assessment if:

- the consumer scored LESS THAN 2 on either Item 4 (medicine) or Item 5 (financial management) AND you have determined that the consumer has no physical disabilities or problems with English literacy that may account for the consumer not being independent on these items OR
- the consumer scored 0 on Item 8.

Behaviour ☐

Refer for a behavioural assessment if:

- the consumer scored LESS THAN 2 on either Item 4 (medicine) or Item 5 (financial management) AND you have determined that the consumer has no physical disabilities or problems with English literacy that may account for the consumer not being independent on these items OR
- the consumer scored 0 on Item 9.

Aids and equipment currently used (tick all that apply)

Self-Care Aids	☐	Medical Care Aids	☐
Support and Mobility Aids	☐	Car Modifications	☐
Communication Aids	☐	Other Goods / Equipment	☐
Aids for Reading	☐	List:	

Comments

Details of person completing this page Summarise issues & arising action on pages 3 & 4 of the Core ONI

Name_____ Designation_____ Agency_____

Sign_____ Date_____ Contact number_____

If information needs updating, indicate below and record updated information on a new FP

This information has been updated ☐ Date: _____

Name: _____ Sign: _____

Health Conditions Profile

Agency _____

Record Unique Record Number

__ __ __ __ __ __ __ __ __ __ __ __

Date of birth *dd/mm/yyyy* _____ / _____ / _____

or affix label here

Overall health

In general, would you say your health is?

- Excellent ☐
- Very good ☐
- Good ☐
- Fair ☐
- Poor ☐

Consider Functional Profile

How much bodily pain have you had during the past 4 weeks?

- None ☐
- Very Mild ☐
- Moderate ☐
- Severe ☐
- Very Severe ☐

Consider Functional Profile

How much did your health interfere with your normal activities (outside and/or inside the home) during the past 4 weeks?

- Not at all ☐
- Slightly ☐
- Moderately ☐
- Quite a bit ☐

Consider Functional Profile

Vision

Is your eyesight for reading (with your glasses)?		Is your long distance eyesight (with your glasses)?	
Excellent	☐	Excellent	☐
Good	☐	Good	☐
Fair	☐	Fair	☐
Poor	☐	Poor	☐

Hearing

Is your hearing (with your hearing aid)?

- Excellent ☐
- Good ☐
- Fair ☐
- Poor ☐

Oral Health

Problems with teeth, gums, dentures, including eligibility to access services?

Yes ☐ No ☐

Comments

If yes, consider referral, Functional Profile and Health Behaviours Profile

Speech/Swallowing

Problems with speech &/or swallowing?

Yes ☐ No ☐

Comments

If yes, consider referral, Functional Profile and Health Behaviours Profile

Falls

Have you had a fall inside/outside the home in the past 6 months?

Yes ☐ No ☐

If yes, record number of falls _____

Consider both Functional Profile and need for referral if the consumer has any problems with vision, hearing or falls.

Feet

Problems with one or both feet?

Yes ☐ No ☐

Comments

Vaccinations

	Date:
Influenza	☐
Pneumococcus	☐
Tetanus	☐
Other	☐

Driving

Drives a motor vehicle?

Yes ☐ No ☐

Fit to drive? *(Refer AustRoads Guidelines)*

Yes ☐ No ☐

Comments

Continence

Leaking urine?	Never	☐
	Sometimes	☐
	Often	☐
Is this related to coughing or sneezing?	Yes	☐
	No	☐
Faecal soiling/change of bowel habit	Never	☐
	Sometimes	☐
	Often	☐

Comments

Height and weight

N/A ☐

Weight _____ kg

Height _____ m

BMI _____

BP/Pulses

N/A ☐

Systolic BP _____ mm/Hg

Diastolic BP _____ mm/Hg

Pulse ☐ Regular ☐ Irregular

Pulse rate _____

Consider check for postural hypotension?

Yes ☐ No ☐

Details of person completing this page

Summarise issues & arising action on pages 3 & 4 of the Core ONI

Name_____ Designation_____ Agency_____

Sign_____ Date_____ Contact number_____

If information needs updating, indicate below and record updated information on a new HC

This information has been updated ☐ Date: _____

Name: _____ Sign: _____

Health Conditions Profile

Agency _____

Record Unique Record Number

__ __ __ __ __ __ __ __ __ __ __ __

Date of birth *dd/mm/yyyy* _____ / _____ / _____

or affix label here

Health conditions as reported by consumer or carer

Include all relevant issues eg, allergies, acute medical conditions, disabilities, continence, dental, developmental)

Condition	Condition
1	5
2	6
3	7
4	8

Medical diagnoses confirmed by doctor

Include all issues eg, allergies, acute medical conditions, disabilities, continence, dental, developmental

Diagnosis	Diagnosis
1	5
2	6
3	7
4	8

Current Medicines

Include prescriptions, over-the-counter, bush medicine and alternate products (including other people's medicine)

1	7	13
2	8	14
3	9	15
4	10	16
5	11	17
6	12	18

Cooperation with treatment. Circle:

Does this person generally look after and take her or his own prescribed medication without reminding?	0	Reliable with medication	1	Slightly unreliable	2	Moderately unreliable	3	Extremely unreliable
Is this person willing to take medication when prescribed by a doctor?	0	Always	1	Usually	2	Rarely	3	Never
Does this person cooperate with health services (eg, doctors and/or other health workers)?	0	Always	1	Usually	2	Rarely	3	Never

Webster Pack or similar used for medicine? Yes ☐ No ☐

Review of medications recommended? Yes ☐ No ☐

Comments

Details of person completing this page Summarise issues & arising action on pages 3 & 4 of the Core ONI

Name_____ Designation_____ Agency_____

Sign_____ Date_____ Contact number_____

If information needs updating, indicate below and record updated information on a new HC

This information has been updated ☐ Date: _____

Name: _____ Sign: _____

Carer Profile

Agency _____

Record Unique Record Number

__ __ __ __ __ __ __ __ __ __ __ __

Date of birth *dd/mm/yyyy* _____ / _____ / _____
or affix label here

Need for a Carer

Record **(1)** The consumer cannot be left on their own at any time (whether by day or night) **(2)** The consumer can only be left on their own for some, but not all, of the time (whether by day or night) **(3)** Nil, no Carer required **(99)** Not Applicable – the consumer is the Carer

Carer Availability

Record **(1)** Has a Carer **(2)** Has no Carer **(3)** Not Applicable – no carer required **(98)** Not Applicable – paid Carer **(99)** Not Applicable – the consumer is the Carer

Carer Residency Status

Record **(1)** Yes – Co-resident Carer **(2)** No – Non-resident Carer **(3)** Not Applicable – the consumer has no Carer **(98)** Not Applicable – paid Carer **(99)** Not Applicable – the consumer is the Carer

Relationship of Carer to Care Recipient

Record **(1)** Wife/female partner **(2)** Husband/male partner **(3)** Mother **(4)** Father **(5)** Daughter **(6)** Son **(7)** Daughter-in-law **(8)** Son-in-law **(9)** Other relative – female **(10)** Other relative – male **(11)** Friend/neighbour – female **(12)** Friend/neighbour – male **(98)** Not Applicable – paid Carer **(99)** Not Applicable – the consumer is the Carer

Carer Support

Does Carer have someone to help them?

☐ Yes ☐ No ☐ Not sure ☐ No Carer

Does Carer receive a Carer Payment or Allowance?

☐ Yes ☐ No ☐ Not sure ☐ No Carer

Has Carer been given information about available support services?

☐ Yes ☐ No ☐ Not sure ☐ No Carer

Does Carer need practical training in lifting, managing medicine or other tasks?

☐ Yes ☐ No ☐ Not sure ☐ No Carer

If 'not sure' or 'no' to any of the above, consider the need to provide information and for assistance to arrange required support services.

Current threats to carer arrangements

Tick all that apply

(1) Carer – emotional stress & strain	☐	(4) Carer – factors unrelated to care situation	☐
(2) Carer – acute physical exhaustion/illness	☐	(5) Consumer – increasing needs	☐
(3) Carer – slow physical health deterioration	☐	(6) Consumer – other factors	☐

Are carer arrangements sustainable without additional services or support?

Record **(1)** No, arrangements have already broken down
(2) No, carer arrangements likely to break down within weeks
(3) No, carer arrangements likely to break down within months
(4) Yes, carer arrangements are sustainable without additional support
(5) Don't know

Carer Issue/s	Consider completing on Carer:
If carer requires HACC or HACC-like services	Functional and Living Arrangements Profiles
Health – consider the carer's overall health, age-related problems, disabilities, use of medicines	Health Conditions Profile
Psychosocial – consider the carer's mental health and emotional well-being, personal and social supports, family and personal relationships	Psychosocial Profile
Functional status and activities of daily living– consider the carer's overall health, age-related problems, disabilities	Functional Profile
Health behaviours – consider the carer's lifestyle issues and opportunities for prevention and health promotion	Health Behaviours Profile
Determinants of health – consider the carer's living arrangements, housing, work, financial, legal	Living Arrangements Profile

Comments on carer issues, including whether emergency arrangements are in place

Details of person completing this page Summarise issues & arising action on pages 3 & 4 of the Core ONI

Name_____ Designation_____ Agency_____

Sign_____ Date_____ Contact number_____

If information needs updating, indicate below and record updated information on a new CP

This information has been updated ☐ Date: _____

Name: _____ Sign: _____

March 2004

Health Behaviours Profile

Agency _____

Record Unique Record Number

__ __ __ __ __ __ __ __ __ __ __ __

Date of birth *dd/mm/yyyy* _____ / _____ / _____
or affix label here

Regular health checks

Yes ☐ No ☐

If yes, record last date or year _____

If yes, record health screens in last 2 years (eg, pap smear, breast, prostate)

Smoking

Never smoked ☐

Has quit smoking ☐

Currently smokes ☐

If quit, record when _____

Consider referral if currently a smoker

Alcohol

How often do you have a drink containing alcohol?

Never ☐ *If never, proceed to next section*

Less than monthly ☐

Monthly ☐

Once a week ☐

2-4 times per week ☐

5+ per week ☐

How many standard drinks do you have on a typical day when you are drinking? _____

(Refer to ONI manual for definition of a standard drink)

How often do you have more than 6 standard drinks on one occasion?

Never ☐

Monthly ☐

Once a week ☐

2-4 times per week ☐

5+ per week ☐

Consider referral if alcohol consumption is an issue

Malnutrition

Use the total score below to decide whether action is required.

		Score
Have you lost weight recently **without** trying? *Note: 'recently' means last 6 months. If consumer unsure, ask if clothes are looser etc*	*If 'yes', complete next item* *No 0* *Unsure 2*	
If yes, how much weight have you lost? (in kilograms) 1-5 6-10 11-15 >15 unsure	 *1* *2* *3* *4* *2*	
Have you been eating poorly because of decreased appetite? *Note: decreased appetite means eating less than ¾ of usual food intake. 'Eating poorly' may be due to problems with swallowing and chewing. If so, score yes.*	*yes 1* *no 0*	
Total score		

Total score of 2 or more: consumer at risk of malnutrition. Consider referral to GP or dietitian.

Hydration

Do you regularly drink at least 8 cups of fluid every day?

(A) Yes ☐ (B) No ☐

If answer to question above is (B), have you recently decreased your fluid intake?

(A) No ☐ (B) Yes ☐

If answer is (B) to either of the above, consider referral to GP or health professional

Weight

Underweight ☐

Average ☐

Overweight ☐

Consider referral to dietitian / specialist / comprehensive service if significantly under or over weight

Physical Activity

Would you do at least 30 minutes of moderate physical activity (such as walking or yard work or any other type of exercise) on most days of the week?

Yes ☐ No ☐

Consider referral if 'no'.

Physical fitness

During the past 4 weeks…what was the hardest physical activity you could do for at least 2 minutes?

Very heavy (for example) run, fast pace; carry a heavy load upstairs or uphill (25 lbs, 10 kg) ☐

Heavy (eg) jog, slow pace; climb stairs or a hill at moderate pace ☐

Moderate (eg) walk, medium pace; carry a heavy load level ground (25 lbs, 10 kg) ☐

Light (eg) walk, medium pace; carry a light load on level ground (10 lbs, 5 kg) ☐

Very light (eg) walk, slow pace; wash dishes ☐

Consider both Functional Profile and need for referral if response is 'light' or 'very light'.

Comments, including other relevant issues (eg, other substance use, safe sex practices, mens health issues) and opportunities for health promotion

Details of person completing this page

Summarise issues & arising action on pages 3 & 4 of the Core ONI

Name_____ Designation_____ Agency_____

Sign_____ Date_____ Contact number_____

If information needs updating, indicate below and record updated information on a new HB

This information has been updated ☐ Date: _____

Name: _____ Sign: _____

ONI Priority Rating Tool

Agency _____

Record Unique Record Number

__ __ __ __ __ __ __ __ __ __ __ __

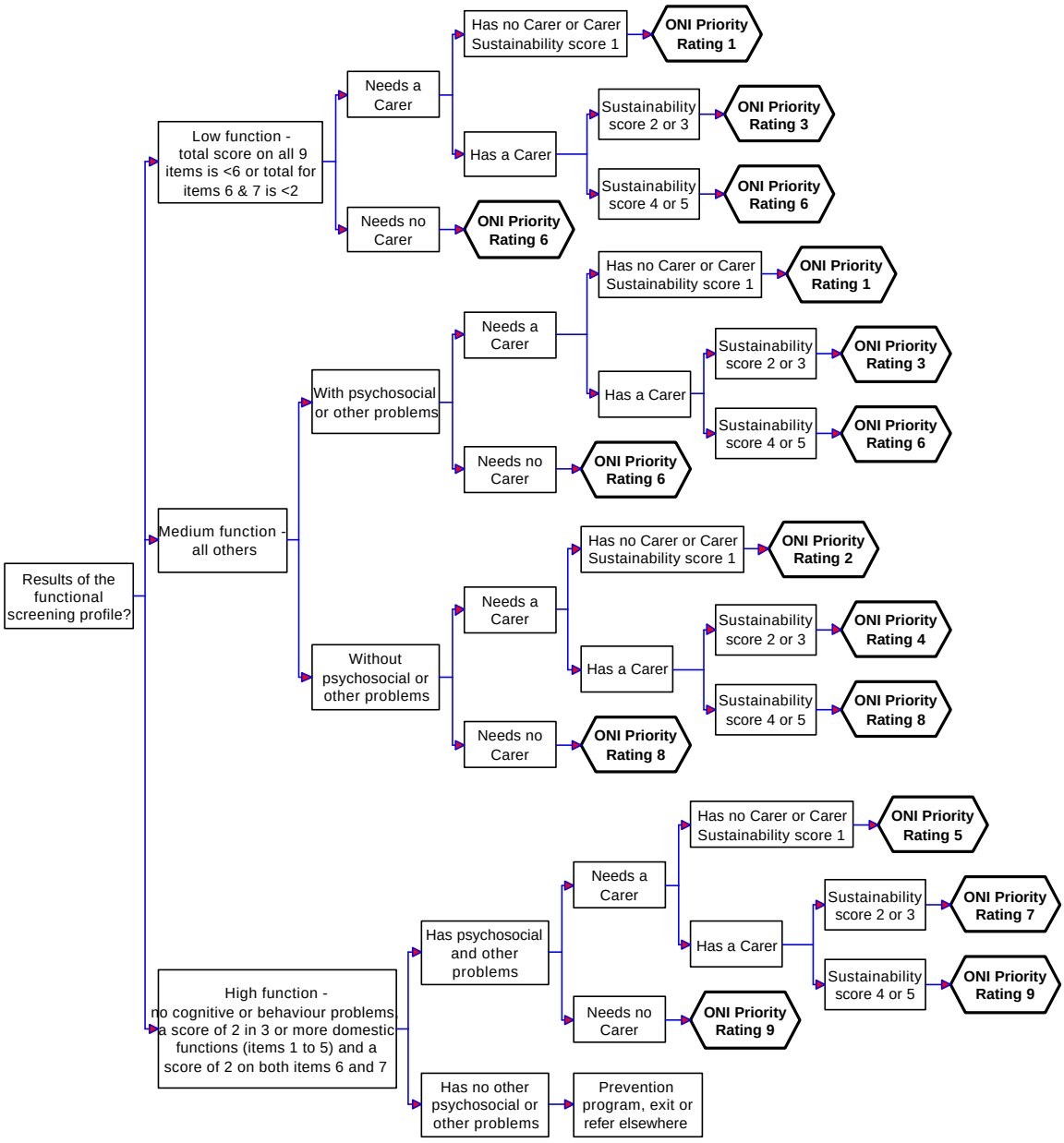
Date of birth *dd/mm/yyyy* _____ / _____ / _____

or affix label here

ONI priority rating: To be completed following screening process to indicate relative priority for service	

Option 1: Decision Making Flow Chart

An alternate way to identify the ONI Priority Rating is shown on page 2 of this profile. Complete either page 1 or page 2, not both. Work through this tool, using either the flow chart below or the matrix over the page. If using the flow chart, circling the relevant box at each step. Definitions of psychosocial and other problems are on page 2. See ONI Manual for more detail. Record the ONI Priority Category on the Core ONI, page 3.



Details of person completing this page Summarise issues & arising action on pages 3 & 4 of the Core ONI

Name_____ Designation_____ Agency_____

Sign_____ Date_____ Contact number_____

If information needs updating, indicate below and record updated information on a new OPR

This information has been updated ☐ Date: _____

Name: _____ Sign: _____

ONI Priority Rating Tool

Agency _____

Record Unique Record Number

__ __ __ __ __ __ __ __ __ __ __ __

Date of birth *dd/mm/yyyy* _____ / _____ / _____
or affix label here

ONI priority rating: To be completed following screening process to indicate relative priority for service

Option 2: Decision Making Matrix

This is an alternate way to identify the ONI Priority Rating shown in more detail on page 1 of this profile. Complete either page 1 or page 2, not both.
Definitions of psychosocial and other problems are below. See ONI Manual for more detail. Record the ONI Priority Category on the Core ONI, page 3

RISK (all rated in Carer Profile)	**NEED**			
	Low function Total score on all 9 items is <6 or total for items 6 & 7 is <2	**Medium function** (not Low or High Function)		**High function but psychosocial or other problems.** High function - no cognitive or behaviour problems, a score of 2 on 3 or more domestic functions (items 1 to 5) and a score of 2 on both items 6 and 7
		with significant psychosocial or other problems (see below)	**with no significant psychosocial or other problems** (see below)	
Needs a carer but has no carer or carer arrangements have already broken down Need for Carer Status item – score 1 or 2. Carer Availability item – score 2 OR Carer Sustainability item – score 1	**1**	**1**	**2**	**5**
Carer arrangements exist but are unsustainable without additional resources (likely to break down in to weeks to months) Need for Carer Status item – score 1 or 2. Carer Sustainability item – score 2 or 3	**3**	**3**	**4**	**7**
Carer arrangements suitable and sustainable Carer Sustainability item – score 4 or 5 OR **Carer not required** Need for Carer Status item – score 3 or 4	**6**	**6**	**8**	**9**

Psychosocial problems (all in Psychosocial Profile)
K10 score of 30 or more AND/OR
No personal and social support AND/OR
Significant family and personal relationships problems (score of 4 on both items)

Other problems
Consumer mistrusts health and community service providers (Psychosocial Profile) AND
Does not cooperate with health services (Health Conditions Profile) OR
Significant behavioural problems (Functional Profile) OR
Significant cognitive problems (diagnosis of dementia in Health Conditions Profile or cognitive problems (Functional Profile) OR
Decision-making problems (Living Arrangements Profile)

Note: If the relevant profile is not completed, rate that the person has no problems. For example, if no Carer Profile is completed, rate the consumer as having no carer risks.

Details of person completing this page Summarise issues & arising action on pages 3 & 4 of the Core ONI

Name_____ Designation_____ Agency_____

Sign_____ Date_____ Contact number_____

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HACC MDS Supplementary Items

Complete only if the Living Arrangements and/or Carer Profile not completed. Otherwise, leave blank.

Agency _____

Record Unique Record Number

__ __ __ __ __ __ __ __ __ __ __ __

Date of birth *dd/mm/yyyy* _____ / _____ / _____
or affix label here

Living arrangements

Record:
(1) Lives alone
(2) Lives with family
(3) Lives with others
(99) Not stated/inadequately described

Accommodation

Record:
(1) Private residence – owned/purchasing
(2) Private residence – private rental
(3) Private residence – public rental
(4) Private residence – mobile home
(5) Independent living unit within a retirement village
(6) Boarding house/private hotel
(7) Short term crisis, emergency or transitional accommodation facility
(8) Domestic-scale supported living facility
(9) Supported accommodation facility
(10) Residential aged care facility
(11) Psychiatric / mental health community care facility
(12) Public place/temporary shelter
(13) Private residence rented from Aboriginal Community
(14) Temporary shelter within an Aboriginal Community
(19) Other
(99) Not stated / inadequately described

Carer availability

Record:
(1) Has a Carer
(2) Has no Carer
(3) Not Applicable – no carer required
(98) Not Applicable – paid Carer
(99) Not Applicable – the consumer is the Carer

Carer Residency Status

Record:
(1) Yes – Co-resident Carer
(2) No – Non-resident Carer
(3) Not Applicable – the consumer has no Carer
(98) Not Applicable – paid Carer
(99) Not Applicable – the consumer is the Carer

Relationship of Carer to Care Recipient

Record:
(1) Wife/female partner
(2) Husband/male partner
(3) Mother
(4) Father
(5) Daughter
(6) Son
(7) Daughter-in-law
(8) Son-in-law
(9) Other relative – female
(10) Other relative – male
(11) Friend/neighbour – female
(12) Friend/neighbour – male
(98) Not Applicable – paid Carer
(99) Not Applicable – the consumer is the Carer

Comments

Details of person completing this page Summarise issues & arising action on pages 3 & 4 of the core ONI

Name_____ Designation_____ Agency_____

Sign_____ Date_____ Contact number_____

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This information has been updated ☐ Date: _____

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