ERA Initial Contact Information CONTACT DETAILS

If question is irrelevant or information not known, write Not Applicable or NA

Record Agency Assigned Consumer Identifier (initial contact agency)

___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

or affix label here

CONSUMER DETAILS

Title (please circle) Mr Mrs Ms Other _____

Family Name: _____

Given Names: _____

Preferred Name/s: _____

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

Sex (please circle) 1. Male 2. Female

CONTACT DETAILS

Usual Address

_____(number) _____(street)

_____(suburb/locality) _____(postcode)

Postal Address (if different from usual address)

_____(number) _____(street)

_____(suburb/locality) _____(postcode)

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

Comments (including contact address for home visits if different from usual address, directions etc or any other contact issues)

WHO THE AGENCY CAN CONTACT IF NECESSARY

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

Person 1 Name

Contact details

_____(number) _____(street)

_____(suburb/locality) _____(postcode)

Phone: _____

Relationship to client

Person 2 Name

Contact details

_____(number) _____(street)

_____(suburb/locality) _____(postcode)

Phone: _____

Relationship to client

GENERAL PRACTITIONER (IF NO GP, WRITE NA)

Name

Address

_____(number) _____(street)

_____(suburb/locality) _____(postcode)

Phone:

Fax:

Email:

Office Use Only

Screener's Name_____ Designation/Agency_____

Sign_____ Date_____ Contact number_____

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

This information has been updated ☐ Date: _____

Name: _____ Sign: _____

ERA Initial Contact Information
SERVICE ENTRY DATA SET

If information not applicable or not known, record 99

Record Agency Assigned Consumer Identifier (initial contact agency)

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

or affix label here

SERVICE ENTRY DATA SET

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 relevant)

Country of Birth
Record: (1) Australia. (2) Other.

If other, specify _____

Indigenous Status
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.
(4) Neither Aboriginal nor 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 details below)
(3) Disability Support Pension
(4) Carer Payment (pension)
(5) Unemployment related benefits
(6) Other gov pension or benefit
(7) No gov pension or benefit

Pension/Benefit Card Number

Medicare Number

Health Care Card Number

DVA Card Status
Record: (1) No DVA Card
(2) Yes – Gold Card
(3) Yes – White Card
(4) Yes - Other DVA Card

DVA Card Number

Insurance Status
Tick all that apply:

(1)	None	
(2)	Private health insurance - basic cover only	
(3)	Private health insurance - including extras cover	
(4)	Private health insurance - extras cover only	
(5)	Motor vehicle accident insurance	
(6)	Workers compensation	
(7)	Other 3rd party	
(8)	Ambulance fund	

Health Insurer Name and Card Number

Office Use Only

Screener's Name_____ Designation/Agency_____

Sign_____ Date_____ Contact number_____

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

This information has been updated ☐ Date: _____

Name: _____ Sign: _____

ERA Initial Needs Identification
INI SUMMARY & ACTION PLAN
If question is irrelevant or information not known, write Not Applicable or NA

Record Agency Assigned Consumer Identifier (initial contact agency)

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

or affix label here

WHY THE CONSUMER IS SEEKING SERVICES

Description of problem or issue as identified by the consumer or referring agency		Action required
1		
2		
3		
4		
Description of other issues as identified by the consumer or in the ongoing needs identification process		
1		
3		
4		

ACTION REQUIRED: Code

(1) Service provision – see Initial Action Plan
(2) Specialist assessment
(3) Comprehensive assessment
(4) Nil: Consumer ineligible for service.
(5) Nil: Referred elsewhere.
(6) Nil: Advise/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: Requested service not available.
(10) Nil: Requested service not accessible (eg, due to long waiting time, inaccessible location).

CONSUMER PERMISSION TO PROCEED

Yes No

If yes, proceed to next section. If no, finalise initial action plan on next page.

CURRENT SERVICES

Record services used in the last three months

Service	Record contact details or other information as appropriate

Consider all health and community services, including (but not limited to) 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.

Office Use Only

Screener's Name_____ Designation/Agency_____

Sign_____ Date_____ Contact number_____

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

This information has been updated ☐ Date: _____

Name: _____ Sign: _____

ERA Initial Needs Identification
INI SUMMARY & ACTION PLAN
If question is irrelevant or information not known, write Not Applicable or NA

Record Agency Assigned Consumer Identifier (initial contact agency)

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

or affix label here

OTHER CONSUMER ISSUES

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

After completing the relevant supplementary profiles, finalise the Initial Action Plan below.

INITIAL 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 initial action required.

TO BE REFERRED TO:

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

Agency/health professional: Complete in legible text. If you will be continuing to see the client, include yourself in the list of agencies/professionals for referral
For: Record purpose of referral in legible text
Consumer Consent: Record (1) Yes, consumer consents to referral and to sharing of information as specified on consumer consent form (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 INI (4) to carer/guardian (4) other
Date: Record date referral actually made. If no referral actually made, leave blank

Alerts (including any relevant comments on risk or urgency).

.

Office Use Only

Screener's Name_____ Designation/Agency_____

Sign_____ Date_____ Contact number_____

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

This information has been updated ☐ Date: _____

Name: _____ Sign: _____

ERA Initial Needs Identification LIVING ARRANGEMENTS

If information not applicable or not known, record 99

Record Agency Assigned Consumer Identifier (initial contact agency)

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

or affix label here

Living arrangements
Record: (1) Lives alone (2) Lives with family (3) Lives with others

Comments on living arrangements, including family arrangements

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

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) Other

Comments on employment

FINANCIAL AND LEGAL PROFILE

Mental Health Act status
Record (1) Voluntary (2) Involuntary (3) CTO (4) N/A

Other legal order (circle one)

Yes No

If yes, specify: _____

Decision-making responsibility
Record: (1) Self (2) Enduring POA (3) Guardian

Is the person capable of making their own decisions? (circle one)

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) POA (3) Administrator (4) Parent or Guardian

Cost of living decisions
Because of limited income, during the last month have you made any trade-offs among purchasing any of the following: prescribed medications, necessary medical care, adequate food, home care?

Yes No Not sure

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

CARER PROFILE

Carer Availability
Record (1) Has a Carer (2) Has no Carer (3) Not Applicable – no carer required (4) 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

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

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, have already broken down (2) Yes, but only weeks (3) Yes, months (4) Yes, years (5) Don't know

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

If there are carer issues, complete a separate INI on the carer.

Comments

Office Use Only Summarise issues & arising action on page 1 & 2 of the INI

Name_____ Designation/Agency_____

Sign_____ Date_____ Contact number_____

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

This information has been updated ☐ Date: _____

Name: _____ Sign: _____

ERA Initial Needs Identification HEALTH CONDITIONS

If question is irrelevant or information not known, write Not Applicable or NA

Record Agency Assigned Consumer Identifier (initial contact agency)

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

or affix label here

Overall health
In general, would you say your health is?

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

Consider Activities of Daily Living

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

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

Consider Activities of Daily Living

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 Activities of Daily Living

Vision

Is your eyesight for reading (with your glasses)?

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

Is your long distance eyesight (with your glasses)?

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

Hearing
Is your hearing (with your hearing aid)?

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

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 Activities of Daily Living and need for referral if the consumer has any problems with vision, hearing or falls.

Health conditions (include all issues eg, allergies, acute medical conditions, disabilities, continence, dental, developmental)

Condition	GP confirmed?	Condition	GP confirmed?
1		5	
2		6	
3		7	
4		8	

Current Medications – include prescriptions, over-the-counter and alternate products

1	5
2	6
3	7
4	8

Note: Polypharmacy may suggest a medication review is desirable

Comments

Office Use Only Summarise issues & arising action on page 1 & 2 of the INI

Name_____ Designation/Agency_____

Sign_____ Date_____ Contact number_____

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

This information has been updated ☐ Date: _____

Name: _____ Sign: _____

ERA Initial Needs Identification **PSYCHOSOCIAL PROFILE**

If question is irrelevant or information not known, write Not Applicable or NA

Record Agency Assigned Client Identifier (initial contact agency)

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

or affix label here

EMOTIONAL WELLBEING

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	4	Most of the time
2	A little of the time	5	All of the time
3	Some 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 ☐

No, not at all ☐

Consider referral & Activities of Daily Living

Comment on personal and social support, including opportunities

FAMILY AND PERSONAL RELATIONSHIPS

Comments

DISABILITY

Is the person likely to be eligible for disability services (circle yes only if they clearly meet all of the criteria below)?

Yes No D/K

Eligibility criteria (tick)

Has a disability attributed to an intellectual disability or a sensory, physical or neurological impairment or brain injury ☐

The disability is permanent or likely to be permanent ☐

Substantially reduced capacity in self-care/management or mobility or communication or learning ☐

Need for continuing support ☐

Office Use Only Summarise issues & arising action on page 1 & 2 of the INI

Name_____ Designation/Agency_____

Sign_____ Date_____ Contact number_____

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

This information has been updated ☐ Date: _____

Name: _____ Sign: _____

ERA Initial Needs Identification FUNCTIONAL PROFILE

Record Agency Assigned Consumer Identifier (initial contact agency)

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

or affix label here

ACTIVITIES OF DAILY LIVING (FUNCTIONAL SCREEN)

Questions to ask the consumer (or the person who represents the consumer)[1].

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 or with the use of a walker, or crutches etc	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.

1 Reproduced from the OARS/MFAQ. Copyright: the Center for the Study of Aging and Human Development, Duke University Medical Center, Durham, North Carolina. Used with permission. Questions 1, 6 and 7 have been modified.

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Name_____ Designation/Agency_____

Sign_____ Date_____ Contact number_____

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This information has been updated ☐ Date: _____

Name: _____ Sign: _____

ERA Initial Needs Identification FUNCTIONAL PROFILE

Record Agency Assigned Consumer Identifier (initial contact agency)

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

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 SCREEN

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:

1. 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
2. the consumer scored 0 on Item 9.

Comments

AIDS AND EQUIPMENT CURRENTLY USED

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

Office Use Only Summarise issues & arising action on page 1 & 2 of the INI

Name_____ Designation/Agency_____

Sign_____ Date_____ Contact number_____

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Name: _____ Sign: _____

ERA Initial Needs Identification HEALTH BEHAVIOURS

If question is irrelevant or information not known, write Not Applicable or NA

Record Agency Assigned Consumer Identifier (initial contact agency)

___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

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*

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?

_____

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

Nutrition

These questions may not apply to all (eg those with particular conditions or lifestyles). If a question has already been answered in a previous section, record a score based on the previous answer. Use the total score to decide whether action is required.

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

Total score: 0-3 'good', 4-5 'moderate', 6-29 'high risk'. Note that these totals have only been validated for older people. Use your judgement for other age groups

Weight

Appearance

Underweight ☐

Average ☐

Overweight ☐

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

Physical Activity

Would you accumulate 30 minutes or more of moderate intensity physical activity 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 Activities of Daily Living 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

Office Use Only Summarise issues & arising action on page 1 & 2 of the INI

Name_____ Designation/Agency_____

Sign_____ Date_____ Contact number_____

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This information has been updated ☐ Date: _____

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