ANNUAL CLIENT CHECKLIST

Client Name:		Client Number:		Program:	
Reviewer:		Date of Review:		Method:	

CLIENT DETAILS:

Pension Number Recorded?	◯ Yes	◯ No:			
Medicare Number Recorded?	◯ Yes	◯ No:			
Change to Phone Number?	◯ No	◯ Yes:		Mobile?:	
Change to GP?	◯ No	◯ Yes:			
Change to Emergency Contacts?	◯ No	◯ Yes:			

GENERAL HEALTH: in the last 3 months have any of the following occurred?

Has the client had changes in circumstances?	◯ No	◯ Yes:	
Has the client's health changed?	◯ No	◯ Yes:	
Has the client's health improved?	◯ No	◯ Yes:	
Has the client had a hospital admission?	◯ No	◯ Yes:	
Has the client had any falls/near misses?	◯ No	◯ Yes:	
Has there been the death of someone close to the client?	◯ No	◯ Yes:	
Has a family member or support person moved from the region?	◯ No	◯ Yes:	
Has a family member or support person moved into the region?	◯ No	◯ Yes:	
Does the client require Oxygen?	◯ No	◯ Yes:	
Has the client noticed any change in their memory?	◯ No	◯ Yes:	

FUNCTIONAL REVIEW:

Can the client manage their housework? ◯ Yes ◯ No: ☐ Floors ☐ Bedding ☐ Bathroom/Toilet

Can the client drive a car? ◯ Yes ◯ No

Disability parking permit? ◯ Yes ◯ No

Does a partner/family member drive? ◯ Yes ◯ No

Taxi concession card? ◯ Yes ◯ No

Does the client have regular contact with anyone? ◯ Yes ◯ No

Does the client attend any clubs; groups/PAGS? ◯ Yes: specify

◯ No: are they interested in doing so? ◯ Yes ◯ No

Any boxes/writing that turns red are flags for the client to be referred back to Assessment/RAS/ACAS for a full review

Do they prepare their own meals? ◉ Yes ○ No: who does?

Do they do their own shopping? ○ Yes ○ No: who does?

Do they pay their own bills? ○ Yes ○ No: who does?

Do they take their own medication? ○ Yes ○ No: Who assists?

Can they use a telephone independently? ○ Yes ○ No Voicemail? ○ Yes ○ No

Do they have a Personal Alarm Unit? ○ Yes ○ No: are they interested in getting one? ○ Yes ○ No

Do they walk independently? ○ No aides ○ Walking stick ○ Walking frame ○ Wheelchair

Are they able to transfer independently? ○ Yes ○ No:

Have they had an assessment from any of the following professionals?

☐ Occupational Therapist ☐ Physiotherapist ☐ Podiatrist ☐ Hearing Test

☐ Vision Test ☐ Dietitian ☐ Other:

Can they manage all aspects of their person care? ○ Yes

○ No: please specify

Have they had an ACAS assessment? ○ No ○ Yes: do they know what approvals they have? ☐ No

☐ Permanent Care ☐ Respite ☐ Home Care Package

SAFETY ITEMS:

Do you have an Emergency Plan in Place? ○ Yes ○ No: Do they want help to write one? ○ Yes ○ No

Is the client on the Community Support Register? ○ Yes ○ No

GENERAL COMMENTS:

Is there anything else the client would like to discuss further?

General comments to pass on to Service Coordinators and/or Assessment Staff:

OUTCOME OF CHECKLIST

○ No significant change- service to remain as is ○ Refer back to Assessment /RAS/ACAS for follow up

Any boxes/writing that turns red are flags for the client to be referred back to Assessment/RAS/ACAS for a full review