Department of Health

health

Service coordination tool templates 2012

User guide

State Government Victoria

Service coordination tool templates 2012

User guide

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This document is also available in PDF format on the internet at www.health.vic.gov.au/pcps/coordination
Published by the Integrated Care Branch, Victorian Government, Department of Health, Melbourne, Victoria.

Authorised and published by the Victorian Government, 50 Lonsdale St, Melbourne.

June 2012 (1206018)
Print managed by Finsbury Green. Printed on sustainable paper.

Disclaimer

The *Service coordination tool templates 2012 user guide* provides broad guidance to assist and support health and human services in the use of the service coordination tool templates. It is not intended as legal advice nor as a comprehensive analysis of privacy law. Where complex issues arise, it may be appropriate to seek legal advice.

Contents

Acronyms and definitions

Acronyms

ACAS	Aged Care Assessment Service
ACCHO	Aboriginal Community Controlled Health Organisation
ACCO	Aboriginal Community Controlled Organisation
AHLO	Aboriginal Hospital Liaison Officer
AIPA	Australian Indigenous Psychologists Association
CACP	Community Aged Care Package
GP	general practitioner
HACC	Home and Community Care
HARP	Hospital Admission Risk Program
INI	initial needs identification
MDS	minimum data set
PCP	Primary Care Partnership
PDRSS	Psychiatric Disability Rehabilitation and Support Services
SACS	Sub-acute Ambulatory Care Services
SCTT	Service coordination tool template
SSP	Shared support plan
VPTAS	Victorian Patient Transport Assistance Scheme

Definitions

Authorised representative	This means the consumer's guardian, or attorney under an enduring power of attorney, or agent under the *Medical Treatment Act 1988,* the administrator or a parent if the consumer is a child, or the 'person responsible' under the *Guardianship and Administration Act 1986* (for more information see <www.publicadvocate.vic.gov.au>).
Carer (unpaid)	A person(s) who, through family relationship or friendship, looks after a frail, older person or someone with a disability or chronic illness. Carers look after these people in the community or in their own homes.
General practice	General practice provides primary medical health services and may include GPs, practice managers, practice nurses and other allied health/medical specialist services.
Health service	Health service as defined in the Health Records Act 2001. See: <http://www.health.vic.gov.au/healthrecords>.

In this document the term 'Aboriginal' is used and is inclusive of both Aboriginal and Torres Strait Islander peoples.

Introduction

About this guide

The *SCTT 2012 user guide* is a practical resource to assist service providers to use the service coordination tool templates (SCTT). This guide provides:

- answers to frequently asked questions
- points for service providers to note in completing the SCTT.

This user guide also includes an overview of the general practice referral and the Ambulance Victoria referral templates.

The user guide can be downloaded at: <www.health.vic.gov.au/pcps/sctt>.

Frequently asked questions

What is the SCTT?

The SCTT is a suite of templates developed to facilitate service coordination. They support the collection, recording and sharing of initial contact, initial needs identification, referral, information exchange and care planning information in a standardised way. The SCTT provide consistent information standards to facilitate electronic sharing of information and provide a common language between a wide range of services.

How does the SCTT support better practice?

During a consumer's journey through the service system, information is collected, shared and utilised to improve their health and circumstances. The SCTT provide a standardised way to record this information.

What are the benefits for service providers?

Using SCTT for communication between service providers in Victoria assists them to:

- know what forms are required to make a referral, no matter what organisation they work in
- record, in a consistent manner, information generated by service coordination processes (such as initial contact, initial needs identification, assessment and shared care/case planning)
- be familiar with the data items and formatting, to make completing and reading the templates quicker and more efficient
- consider information across a broad range of health and social domains in accordance with the social model of health
- send quality referrals, exchange information efficiently and develop shared care/case plans
- inform consumers about privacy of information and record consumer consent to share information
- facilitate the coordination of care
- deliver a consumer-centred approach
- share information electronically.

What are the benefits for the consumer?

The SCTT support consumers to experience a streamlined and coordinated service by:

- screening consumers' health and social needs and identifying the services required in a timely manner
- reducing the burden on consumers to repeat the same information to each service provider
- assisting more timely access to the services required as a result of higher quality referrals
- reducing duplication of assessments and services through more efficient information sharing
- giving consumers more control over the sharing of their information.

How does the SCTT help electronic information sharing?

Progressively information will be shared by exchanging data in the form of HL7 messaging. This means that information sent in a referral can populate directly into the receiving service's client information management system. This can only happen if there are common information/data standards.

What is the SCTT used for?

The SCTT is used for the collection, recording and sharing of information related to:

- initial contact (registration)
- initial needs identification
- referral
- shared care/case planning (shared support plans)
- assessment summary
- exit/discharge information.

The SCTT facilitate obtaining and recording consent to share information.

Who can complete the templates?

The SCTT core and optional templates were developed so that all service providers and/or consumers can complete the templates when relevant for referral.

Which templates do I need to make a referral?

Core referral templates are used to send a referral, with the consumer's consent. These include:

- *Referral cover sheet and acknowledgement* (not required for e-referral)
- *Consumer information*
- *Summary and referral information.*

Relevant optional and supplementary templates may be sent with a referral. The optional/supplementary templates may be used to screen for health and social needs. They should also provide additional information for the services receiving the referral to:

- determine eligibility
- determine priority
- assist with coordinating care.

They should not be used as assessment tools. See pages 74–75 for a summary of the templates.

Service providers should use their professional judgement when using the optional/supplementary templates. Not all optional and supplementary templates will be relevant for every consumer. Depending on available information and relevance to consumer needs, some items within a template may not be required, and it may be appropriate to complete templates partially.

Some programs may indicate particular optional or supplementary templates that are required as a minimum standard for a referral to be progressed.

Do I need to complete and send all of the templates for all consumers?

No. The core referral templates must be sent for all consumers, but only the optional/supplementary templates that are relevant to the individual consumer need to be completed and attached to the referral.

Do I send the consent form with the referral?

No. The *Consent to share information* template is used to record consent for the consumer's information to be shared with other service providers. It is the responsibility of the agency sending the referral to obtain and record consent. Do not send this template to the service provider with a referral, because it may identify information that is not to be shared.

Where can I find the SCTT?

The SCTT is available in most client information management software applications used by health and community service providers. When viewing SCTT on some client information management software applications, they may look different from the hard copy visual standard. However, when shared between service providers via secure electronic referral or when printed, the templates should look the same as the hard copy visual standard. To see if your client management system has SCTT, go to the Information Management & Information Communications Technology website, at: <http://www.health.vic.gov.au/pcps/coordination/info_management.htm>.

SCTT interactive word documents and PDFs are available from: <http://www.health.vic.gov.au/pcps/sctt.htm>.

When is the *Shared support plan* used?

The *Shared support plan* records a care/case coordinated plan for consumers with complex and/or multiple needs who require multiple services.

Why would a consumer need a *Shared support plan?*

A *Shared support plan* is for consumers who require multiple services, to support a coordinated approach. It shows who is involved in the consumer's care, the main issues, consumer goals, planned actions and who is responsible for each action. Documenting consumer goals provides all the service providers, involved in their care, to work towards a common goal.

When do I use the *Referral cover sheet and acknowledgement* template?

Use the *Referral cover sheet and acknowledgement* template when you fax or post the referral. This template will help direct the referral to the right service and the right person. The service receiving the referral will be able to reuse this template to acknowledge that they have received the referral.

What do I use if I want to provide information back to the referral service?

To acknowledge a referral has been received, complete the bottom section of the *Referral cover sheet and acknowledgement* template and send to the referral service. You may use the *Referral cover sheet and acknowledgement* that was originally sent to you. If you receive a referral via an e-referral system, you may acknowledge the referral electronically.

To share information about an assessment, changes to a shared care/case plan or exit/discharge information, use the *Information exchange summary* template.

How is the *Single page screener for health and social needs* template used?

This template was developed in the SCTT 2012 revision to improve initial needs identification practice. It supports service providers to screen for health and social issues that may not be within their area of expertise.

How and when this template is used will depend on the service provider's setting, processes, and consumer group. This template may be completed by the consumer before their appointment (e.g. in the waiting room) or the service provider may complete it with the consumer via telephone or in person.

When is the *GP referral* template and *Ambulance Victoria referral* template used?

The *GP referral* template (formerly VSRF) is for referrals from general practice to other service providers. The *Ambulance Victoria referral* template is for referrals from the Ambulance 000 Referral Service to partnering services.

How often is the SCTT reviewed?

The SCTT is regularly reviewed to ensure that it meet the requirements of the broad range of services using the SCTT. The last review was finalised in 2012. See pages 72–73 to view the revision process and who was involved in the 2012 review.

What is Service coordination?

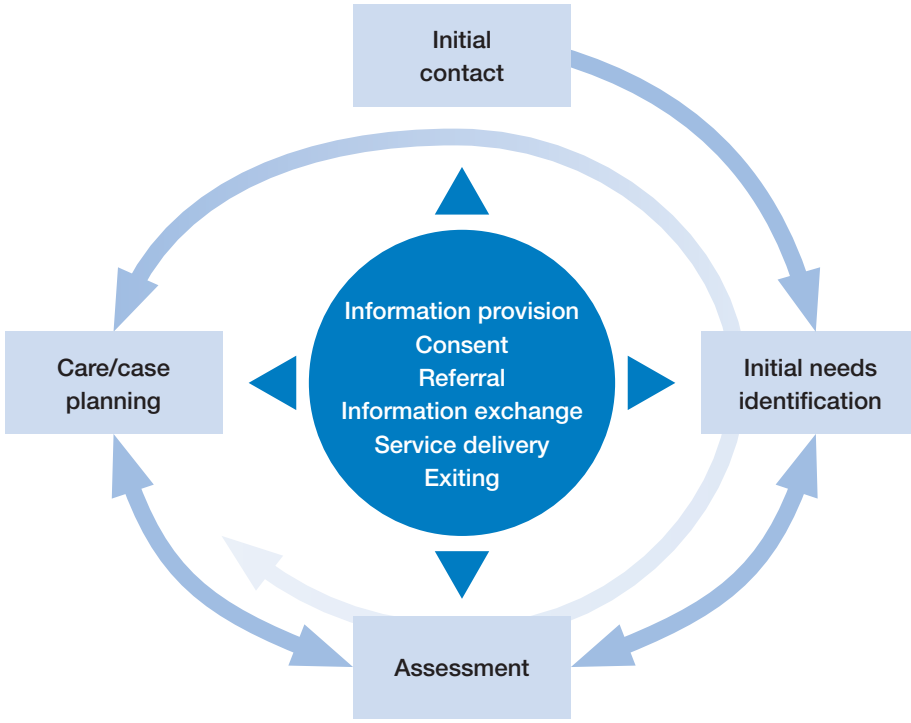
Service coordination places consumers at the centre of service delivery to maximise their opportunities for accessing the most appropriate services they need in an efficient and timely manner. Service coordination enables organisations to remain independent of each other, while working in a cohesive and coordinated way, to give consumers a seamless and integrated response.

Service coordination stems from the *Better access to services – A policy and operational framework* at: <http://www.health.vic.gov.au/pcps/publications/access.htm>. Victoria's agreed service coordination practice standards are outlined in the *Victorian service coordination practice manual* at: <http://www.health.vic.gov.au/pcps/publications/sc_pracmanual.htm>.

The implementation of service coordination is supported by partnerships, policy, practice standards, training and other resources. For details of these resources and where to find them, see pages 69–71.

As shown in Figure 1 Service coordination elements, the key operational elements of service coordination are initial contact, initial needs identification, assessment and care/case planning (see the *Victorian service coordination practice manual).* Processes such as information provision, consent to share information, referral, information exchange, service delivery and exiting can occur at any stage.

Figure 1 Service coordination elements



When and how service coordination operational elements are implemented depends on the consumer need and the service provider setting. For example, elements may be carried out by different people, or simultaneously by the same person. The SCTT is designed to support the elements of service coordination (Figure 2 SCTT aligned with service coordination operational elements).

Figure 2 SCTT aligned with service coordination operational elements

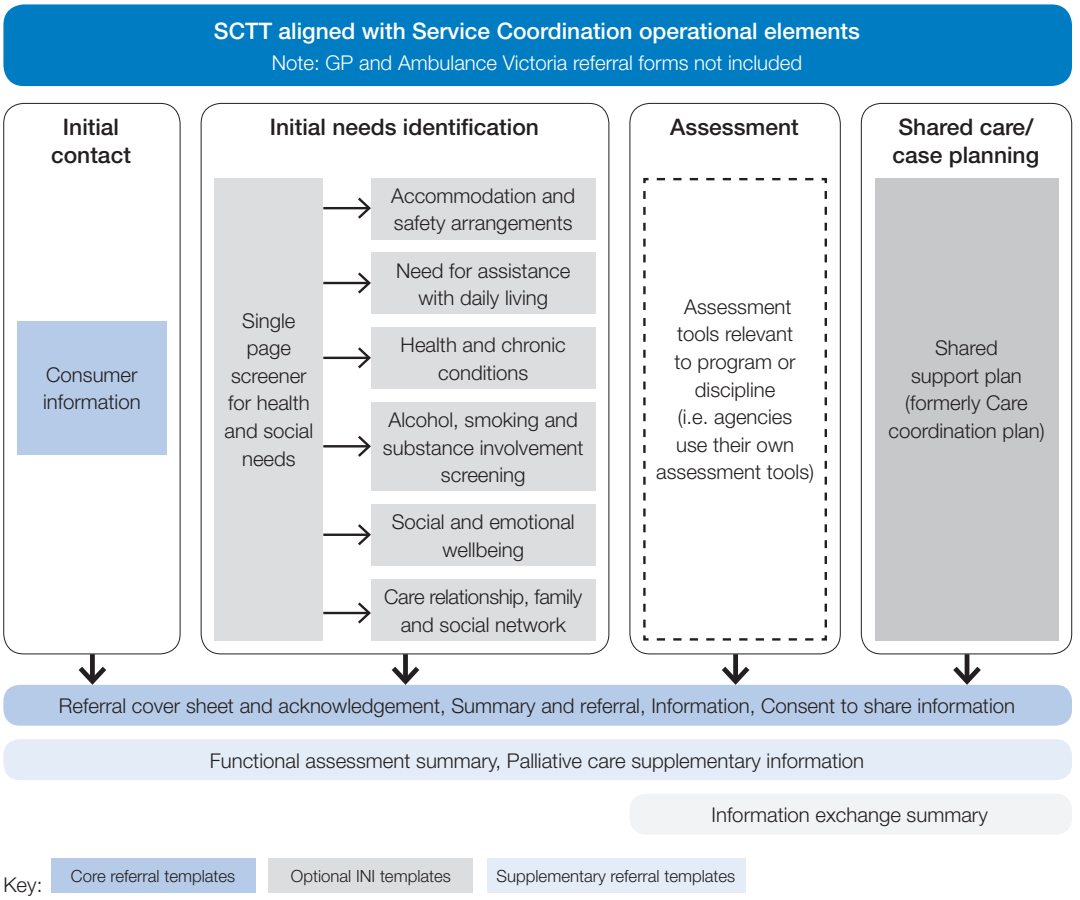
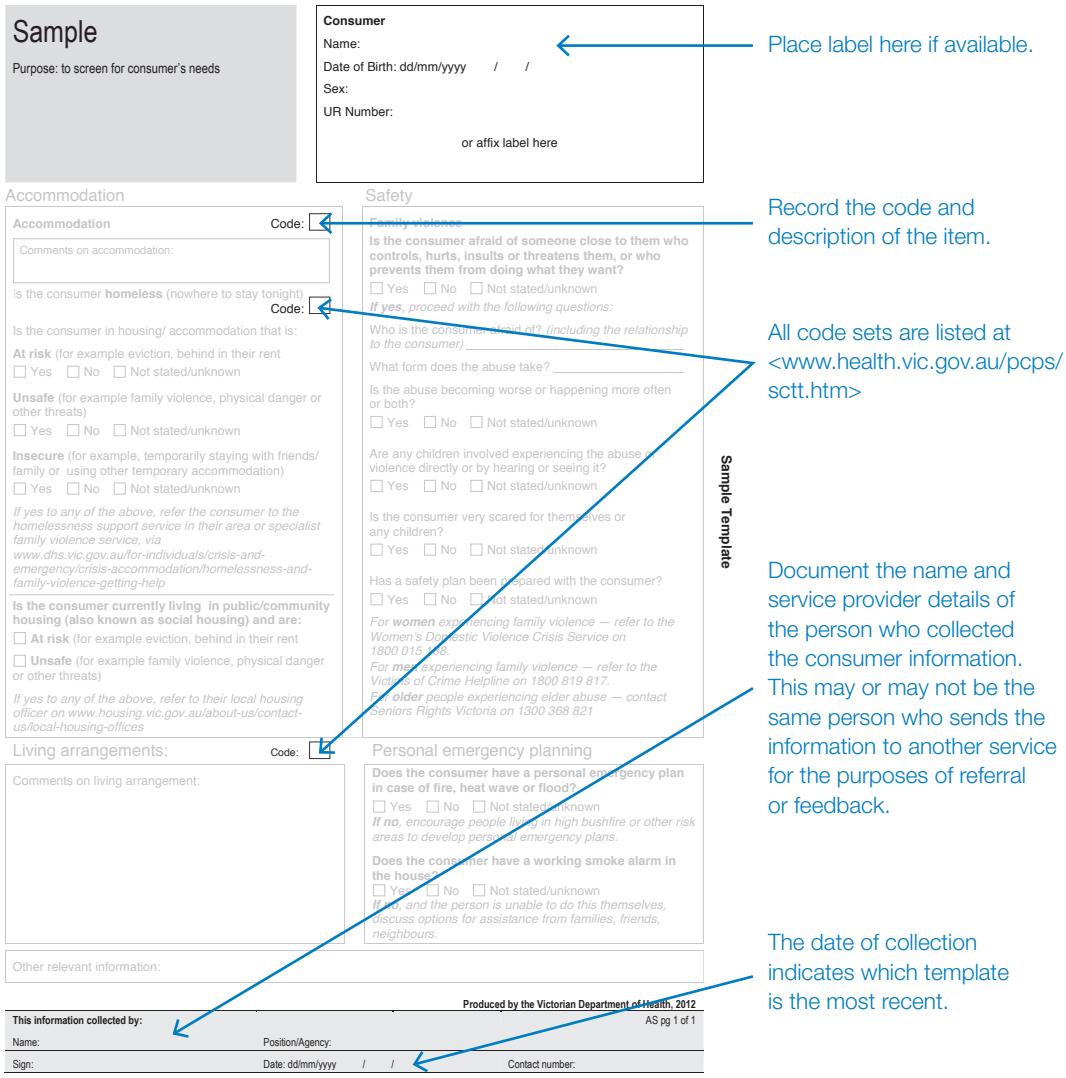


Figure 2 SCTT aligned with service coordination operational elements represents how the SCTT align with the elements within the service coordination framework. It does not represent a consumer pathway through the service system. Service providers may use their own templates to record assessment outcomes and treatment or service plans.

A sample template

Several common features are evident across templates.



Place label here if available.

Record the code and description of the item.

All code sets are listed at <www.health.vic.gov.au/pcps/sctt.htm>

Document the name and service provider details of the person who collected the consumer information. This may or may not be the same person who sends the information to another service for the purposes of referral or feedback.

The date of collection indicates which template is the most recent.

To update consumer information that has previously been recorded, complete the relevant template again and retain a copy of the previous and the amended template.

Core referral templates

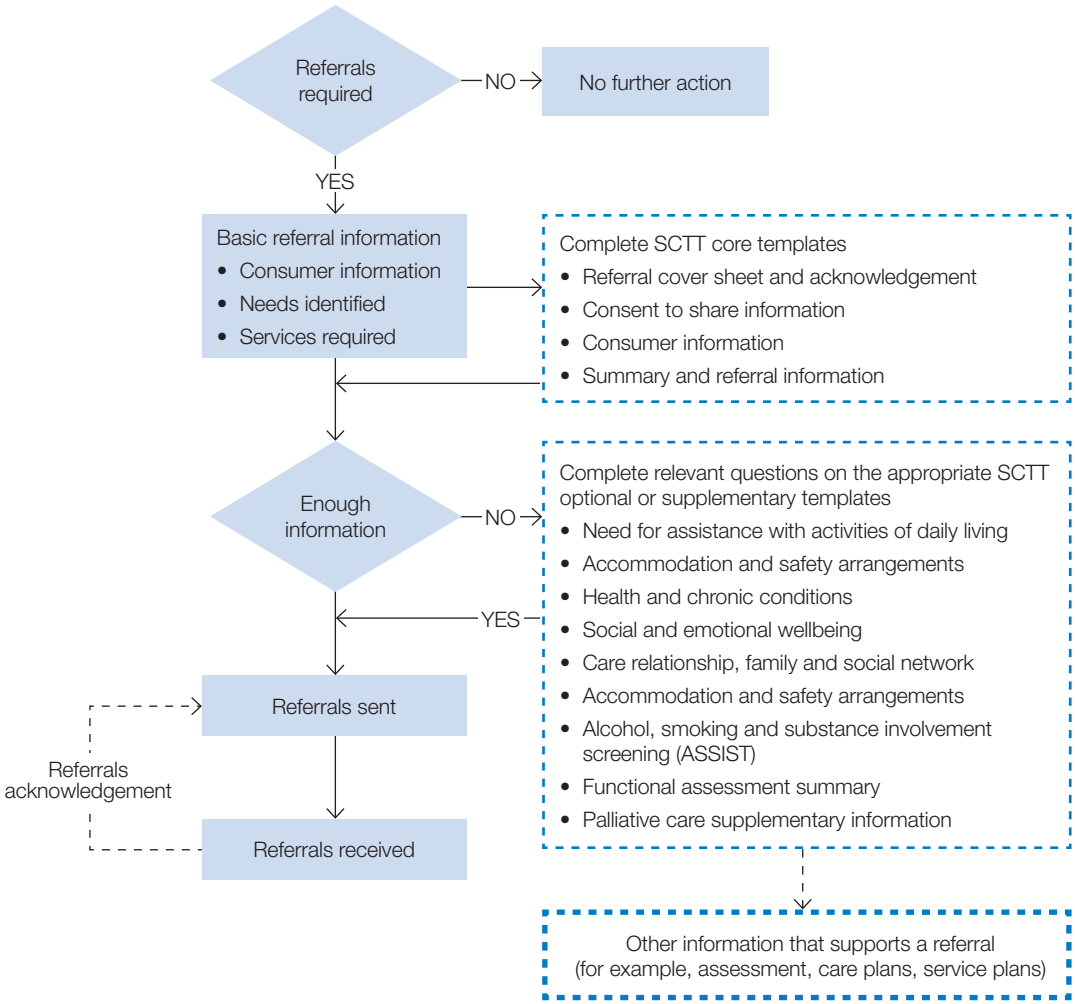
Consent to share information

How to send a referral using the SCTT

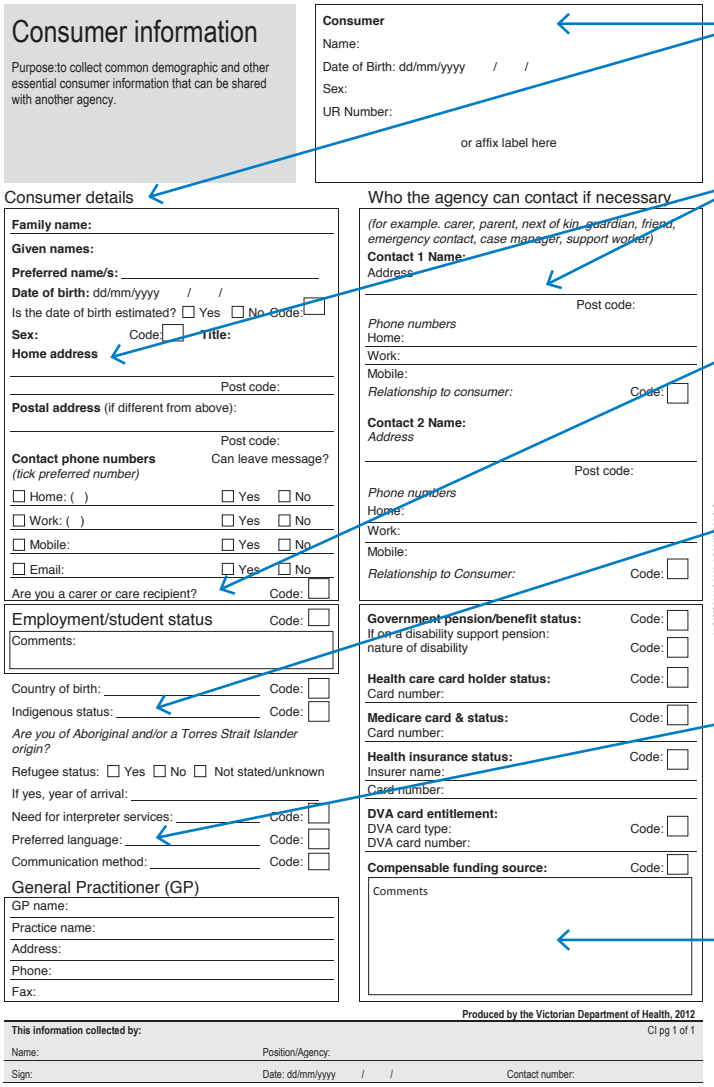
The core referral templates are used to make a referral to another service. These templates contain the minimum information required for an effective referral and for the receiving service to act on the referral.

The diagram below (Figure 3 Referral process) illustrates a simplified referral process and the SCTT templates that are required. Some processes take place prior to the decision for a referral, including initial contact (consumers' first contact with the service system) and initial needs identification (screening of health and social needs). If the consumer has multiple and/or complex needs and is already accessing multiple services, a *Shared support plan* may also be developed during this process and sent with the referral.

Figure 3 Referral process



Consumer information



Consumer information

Purpose:to collect common demographic and other essential consumer information that can be shared with another agency.

Consumer
Name:
Date of Birth: dd/mm/yyyy / /
Sex:
UR Number:
or affix label here

Consumer details

Family name:
Given names:
Preferred name/s:
Date of birth: dd/mm/yyyy / /
Is the date of birth estimated? ☐ Yes ☐ No Code:
Sex: Code: **Title:**
Home address
Post code:
Postal address (if different from above):
Post code:
Contact phone numbers *(tick preferred number)* Can leave message?
☐ Home: ( ) ☐ Yes ☐ No
☐ Work: ( ) ☐ Yes ☐ No
☐ Mobile: ☐ Yes ☐ No
☐ Email: ☐ Yes ☐ No
Are you a carer or care recipient? Code:

Employment/student status Code:
Comments:

Country of birth: Code:
Indigenous status: Code:
Are you of Aboriginal and/or a Torres Strait Islander origin?
Refugee status: ☐ Yes ☐ No ☐ Not stated/unknown
If yes, year of arrival:
Need for interpreter services: Code:
Preferred language: Code:
Communication method: Code:

General Practitioner (GP)
GP name:
Practice name:
Address:
Phone:
Fax:

Who the agency can contact if necessary
(for example. carer, parent, next of kin, guardian, friend, emergency contact, case manager, support worker)
Contact 1 Name:
Address
Post code:
Phone numbers
Home:
Work:
Mobile:
Relationship to consumer: Code:
Contact 2 Name:
Address
Post code:
Phone numbers
Home:
Work:
Mobile:
Relationship to Consumer: Code:

Government pension/benefit status: Code:
If on a disability support pension: nature of disability Code:
Health care card holder status: Code:
Card number:
Medicare card & status: Code:
Card number:
Health insurance status: Code:
Insurer name:
Card number:
DVA card entitlement:
DVA card type: Code:
DVA card number:
Compensable funding source: Code:
Comments

Consumer information

Produced by the Victorian Department of Health, 2012
This information collected by: CI pg 1 of 1
Name: Position/Agency:
Sign: Date: dd/mm/yyyy / / Contact number:

Do not repeat details if a current label can be attached.

Update consumer contact details (such as address and phone number) as details change.

A carer may be a family member or friend who helps with daily tasks.

All Australian-born consumers must be asked about their indigenous status. Refer to page 60 for further information on how to ask this question.

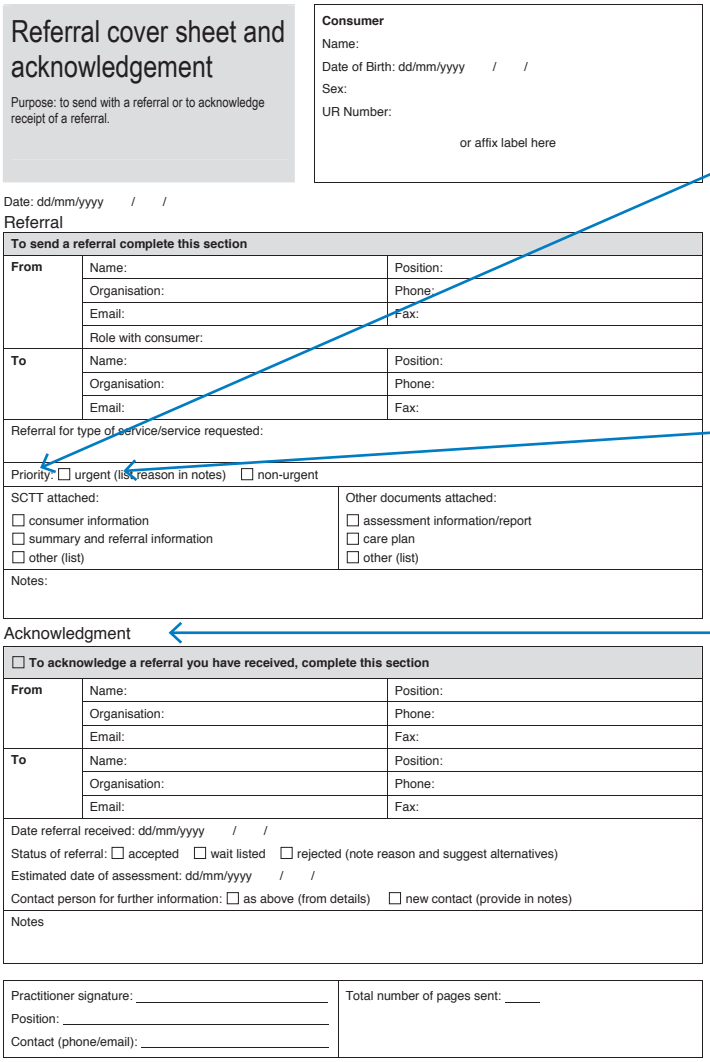
If consumer identifies themselves as Aboriginal, refer to page 62 for more information.

Use the comments box to record any additional comments or relevant consumer information not listed on the template. For example:

- ambulance cover/number
- if using the template for registration record.

The *Referral cover sheet and acknowledgement,* the *Consumer information* template and the *Summary and referral information* template contain the minimum information required for an effective referral.

Referral cover sheet and acknowledgement



Referral cover sheet and acknowledgement

Purpose: to send with a referral or to acknowledge receipt of a referral.

Consumer
Name:
Date of Birth: dd/mm/yyyy / /
Sex:
UR Number:
or affix label here

Date: dd/mm/yyyy / /

Referral

To send a referral complete this section		
From	Name:	Position:
	Organisation:	Phone:
	Email:	Fax:
	Role with consumer:	
To	Name:	Position:
	Organisation:	Phone:
	Email:	Fax:
Referral for type of service/service requested:		
Priority: ☐ urgent (list reason in notes) ☐ non-urgent		
SCTT attached: ☐ consumer information ☐ summary and referral information ☐ other (list)	Other documents attached: ☐ assessment information/report ☐ care plan ☐ other (list)	
Notes:		

Acknowledgment

☐ To acknowledge a referral you have received, complete this section		
From	Name:	Position:
	Organisation:	Phone:
	Email:	Fax:
To	Name:	Position:
	Organisation:	Phone:
	Email:	Fax:
Date referral received: dd/mm/yyyy / /		
Status of referral: ☐ accepted ☐ wait listed ☐ rejected (note reason and suggest alternatives)		
Estimated date of assessment: dd/mm/yyyy / /		
Contact person for further information: ☐ as above (from details) ☐ new contact (provide in notes)		
Notes		

Practitioner signature: _____ Position: _____ Contact (phone/email): _____	Total number of pages sent: _____

Referral cover sheet and acknowledgement

Priority is the relative urgency of this consumer in relation to other consumers who require the same service. Priority is usually determined through initial needs identification, or assessment. The service receiving the referral may change the priority rating based on their program priority criteria.

Urgent is a recommendation that the consumer will have priority over others being seen routinely from a waiting list.

This section is for the receiver of the referral to acknowledge receipt of the referral and advise the referrer of the response.

E-referral systems may have this function built into their systems.

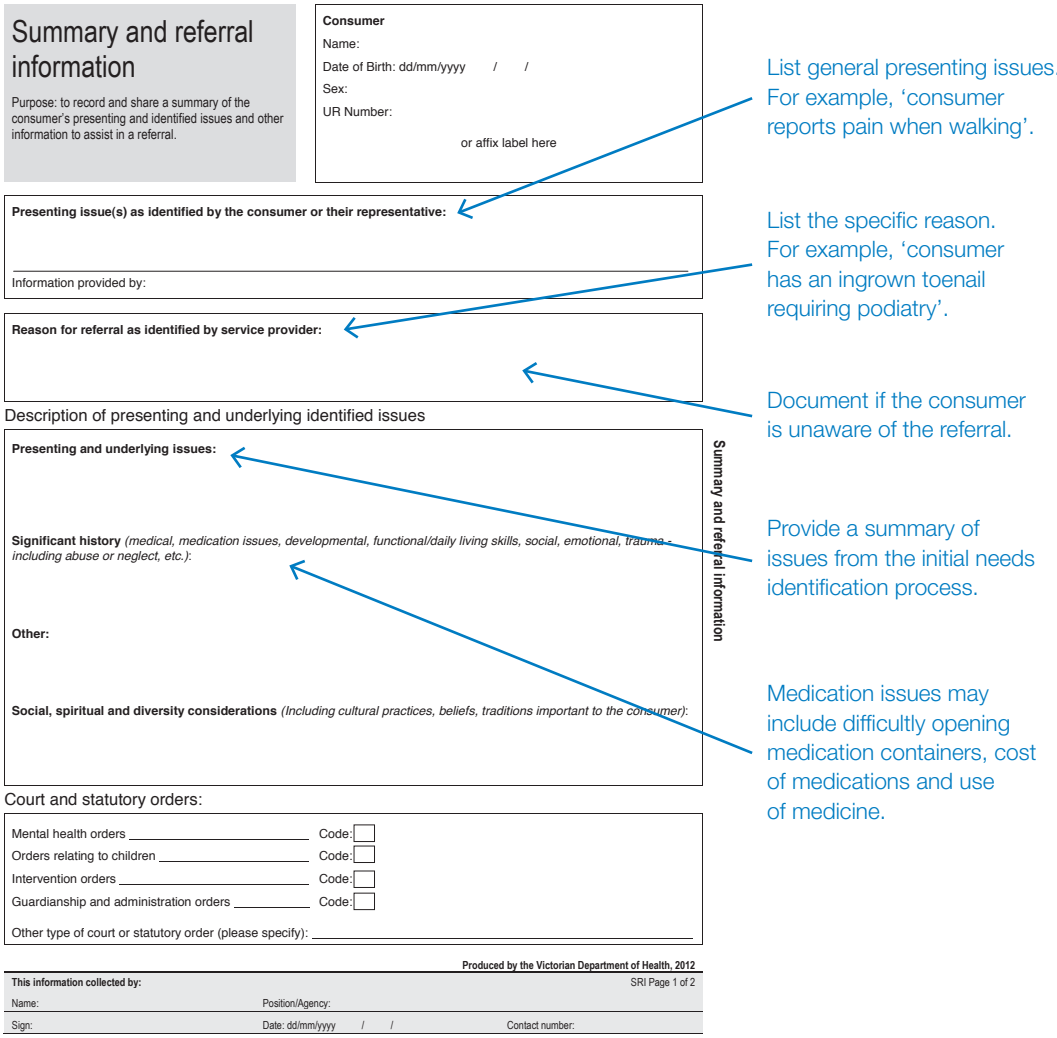
This template reflects a stepped process: the sending service completes the referral half of the template when they send a referral, and the receiving service completes the bottom part of the template and returns it to acknowledge that they have received the referral.

The *Referral cover sheet and acknowledgement,* the *Consumer information* template and the *Summary and referral information* template contain the minimum information required for an effective referral.

It is the duty of care of the person collecting and sending the referral to obtain the consumer's consent to share this information. For more information on consent to share information, including consent requirements for people who do not have the capacity to give consent, refer to page 17.

Summary and referral information

Page 1



Summary and referral information

Purpose: to record and share a summary of the consumer's presenting and identified issues and other information to assist in a referral.

Consumer
Name:
Date of Birth: dd/mm/yyyy / /
Sex:
UR Number:
or affix label here

Presenting issue(s) as identified by the consumer or their representative:

Information provided by:

Reason for referral as identified by service provider:

Description of presenting and underlying identified issues

Presenting and underlying issues:

Significant history *(medical, medication issues, developmental, functional/daily living skills, social, emotional, trauma - including abuse or neglect, etc.)*:

Other:

Social, spiritual and diversity considerations *(Including cultural practices, beliefs, traditions important to the consumer)*:

Summary and referral information

Court and statutory orders:

Mental health orders _____ Code:
Orders relating to children _____ Code:
Intervention orders _____ Code:
Guardianship and administration orders _____ Code:
Other type of court or statutory order (please specify): _____

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This information collected by: SRI Page 1 of 2

Name: Position/Agency:

Sign: Date: dd/mm/yyyy / / Contact number:

List general presenting issues. For example, 'consumer reports pain when walking'.

List the specific reason. For example, 'consumer has an ingrown toenail requiring podiatry'.

Document if the consumer is unaware of the referral.

Provide a summary of issues from the initial needs identification process.

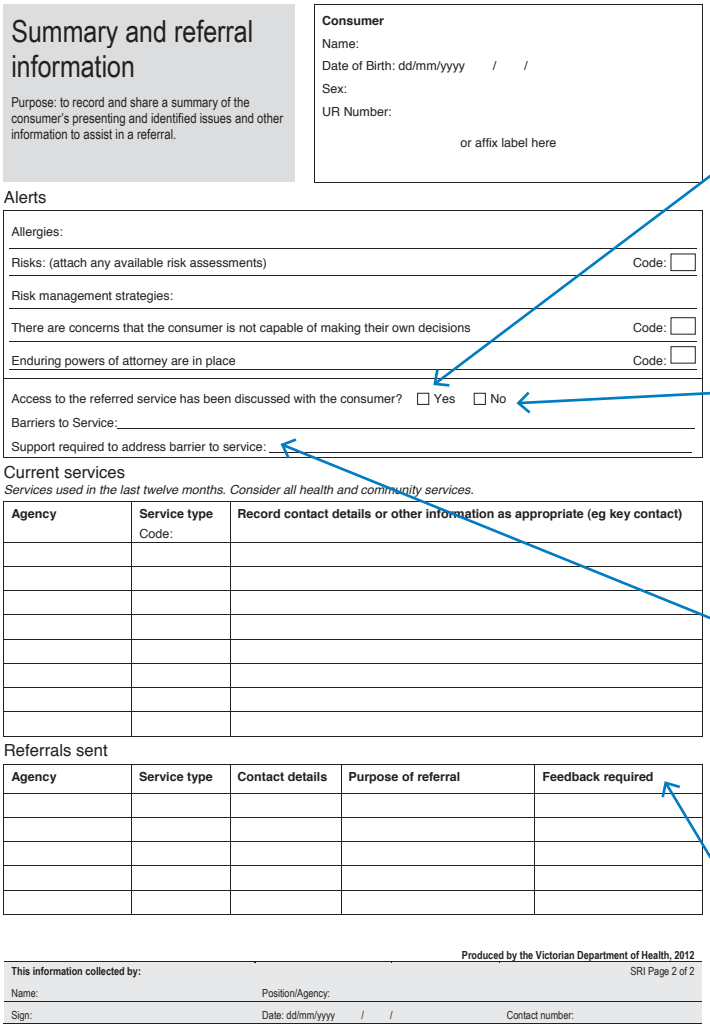
Medication issues may include difficultly opening medication containers, cost of medications and use of medicine.

The *Referral cover sheet and acknowledgement,* the *Consumer information* and the *Summary and referral information* templates contain the minimum information for an effective referral.

Service providers can use this template to summarise initial needs identification.

Summary and referral information

Page 2



Summary and referral information

Purpose: to record and share a summary of the consumer's presenting and identified issues and other information to assist in a referral.

Consumer
Name:
Date of Birth: dd/mm/yyyy / /
Sex:
UR Number:
or affix label here

Alerts

Allergies:
Risks: (attach any available risk assessments) Code:
Risk management strategies:
There are concerns that the consumer is not capable of making their own decisions Code:
Enduring powers of attorney are in place Code:
Access to the referred service has been discussed with the consumer? Yes No
Barriers to Service:
Support required to address barrier to service:

Current services
Services used in the last twelve months. Consider all health and community services.

Agency	Service type Code:	Record contact details or other information as appropriate (eg key contact)

Referrals sent

Agency	Service type	Contact details	Purpose of referral	Feedback required

Produced by the Victorian Department of Health, 2012
This information collected by: SRI Page 2 of 2
Name: Position/Agency:
Sign: Date: dd/mm/yyyy / / Contact number:

Summary and referral information

Transport support options include public transport (MET and V/Line call centres, buses), Taxi Directorate (taxi vouchers: www.transport.vic.gov.au/taxis/mptp), Ambulance Australia (non-emergency transport) and Community Services (for example, local council, volunteer services).

If consumer identifies themselves as Aboriginal refer to page 62 for more information.

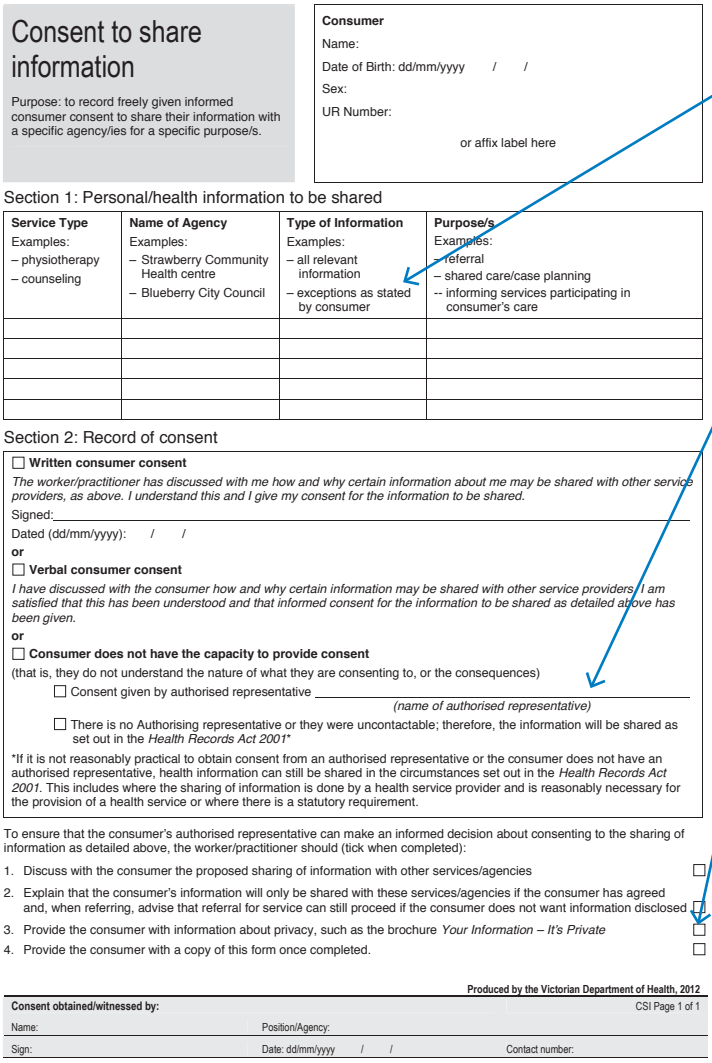
For example, they have difficulty waiting for long periods due to behavioural issues, wheelchair access is required, they have communication and cognitive impairments and require double appointments, consumer may require a home visit.

Feedback required involves the return of evaluative information about an action or process. This should not be confused with acknowledgement, which is a confirmation that something has been done.

For information about health and community services and transport providers in Victoria, refer to the Human Services Directory at: <www.humanservicesdirectory.vic.gov.au>.

Consent to share information

Consent to share information



Consent to share information

Purpose: to record freely given informed consumer consent to share their information with a specific agency/ies for a specific purpose/s.

Consumer

Name:

Date of Birth: dd/mm/yyyy / /

Sex:

UR Number:

or affix label here

Section 1: Personal/health information to be shared

Service Type	Name of Agency	Type of Information	Purpose/s
Examples: – physiotherapy – counseling	Examples: – Strawberry Community Health centre – Blueberry City Council	Examples: – all relevant information – exceptions as stated by consumer	Examples: – referral – shared care/case planning -- informing services participating in consumer's care

Section 2: Record of consent

☐ **Written consumer consent**

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.

Signed:_____

Dated (dd/mm/yyyy): / /

or

☐ **Verbal consumer consent**

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.

or

☐ **Consumer does not have the capacity to provide consent**

(that is, they do not understand the nature of what they are consenting to, or the consequences)

☐ Consent given by authorised representative _____

(name of authorised representative)

☐ There is no Authorising representative or they were uncontactable; therefore, the information will be shared as set out in the *Health Records Act 2001**

**Consent to Share Information*

*If it is not reasonably practical to obtain consent from an authorised representative or the consumer does not have an authorised representative, health information can still be shared in the circumstances set out in the *Health Records Act 2001*. This includes where the sharing of information is done by a health service provider and is reasonably necessary for the provision of a health service or where there is a statutory requirement.

To ensure that the consumer's authorised representative can make an informed decision about consenting to the sharing of information as detailed above, the worker/practitioner should (tick when completed):

1. Discuss with the consumer the proposed sharing of information with other services/agencies ☐
2. Explain that the consumer's information will only be shared with these services/agencies if the consumer has agreed and, when referring, advise that referral for service can still proceed if the consumer does not want information disclosed ☐
3. Provide the consumer with information about privacy, such as the brochure *Your Information – It's Private* ☐
4. Provide the consumer with a copy of this form once completed. ☐

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Consent obtained/witnessed by: CSI Page 1 of 1

Name: Position/Agency:

Sign: Date: dd/mm/yyyy / / Contact number:

Do not send this template to the service provider with a referral, because it may identify information that is not to be shared.

If consent is provided by an authorised representative, document their contact details on the *Consumer information* template.

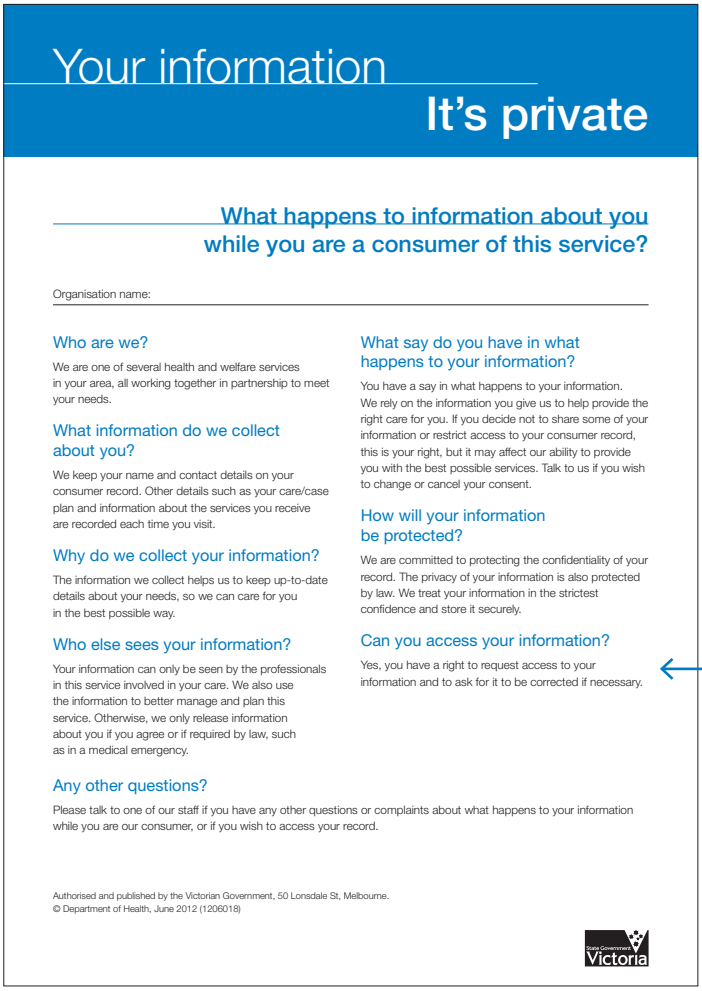
The *Consent to share information* template and the brochure *Your information – It's private* are available in many languages as well as Easy English and can be downloaded at <www.health.vic.gov.au/pcps/sctt>

Consent forms are not required to be included in referral information sent to another service provider. It is the duty of care for the service collecting and sending the information to ensure that informed consent has been obtained.

The *Consent to share information* template complies with the *Health Records Act,* the *Information Privacy Act 2000 (Victorian)* and the *Privacy Act 1988 (Commonwealth).*

If the consumer **refuses consent** to share information, a referral can still proceed. However, the service provider to which the consumer is referred will need to obtain the information they need from the consumer.

Consumer privacy information brochure



Your information
It's private

What happens to information about you while you are a consumer of this service?

Organisation name:

Who are we?

We are one of several health and welfare services in your area, all working together in partnership to meet your needs.

What information do we collect about you?

We keep your name and contact details on your consumer record. Other details such as your care/case plan and information about the services you receive are recorded each time you visit.

Why do we collect your information?

The information we collect helps us to keep up-to-date details about your needs, so we can care for you in the best possible way.

Who else sees your information?

Your information can only be seen by the professionals in this service involved in your care. We also use the information to better manage and plan this service. Otherwise, we only release information about you if you agree or if required by law, such as in a medical emergency.

What say do you have in what happens to your information?

You have a say in what happens to your information. We rely on the information you give us to help provide the right care for you. If you decide not to share some of your information or restrict access to your consumer record, this is your right, but it may affect our ability to provide you with the best possible services. Talk to us if you wish to change or cancel your consent.

How will your information be protected?

We are committed to protecting the confidentiality of your record. The privacy of your information is also protected by law. We treat your information in the strictest confidence and store it securely.

Can you access your information?

Yes, you have a right to request access to your information and to ask for it to be corrected if necessary.

Any other questions?

Please talk to one of our staff if you have any other questions or complaints about what happens to your information while you are our consumer, or if you wish to access your record.

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State Government Victoria

Consumers' access to their information is managed through the *Freedom of Information Act 1982* for public organisations (for example, hospitals) and the *Health Records Act 2001* for private organisations.

At the time of collecting information, the consumer is provided with information about their privacy. The consumer privacy information brochure *Your information – It's private* was developed to assist this process.

Organisations should include their name, and may modify the brochure to ensure it is specific to the organisation.

Consumer privacy information brochures are available in many languages, as well as Easy English at: <www.health.vic.gov.au/pcps/publications/languages_privacy.htm>.

Training is available for organisations through the Office of the Victorian Privacy Commissioner *(Information Privacy Act 2000)* <www.privacy.vic.gov.au/privacy/web2.nsf/pages/home> and the Office of the Health Services Commissioner *(Health Records Act 2001)* <www.health.vic.gov.au/hsc/>.

Translations

Translations of the *Consent to share information* template and *Your information – It's private* brochure are available at <www.health.vic.gov.au/pcps/coordination/privacy.htm>. The languages available are listed below.

Translation list

Albanian
Amharic
Arabic
Armenian
Assyrian
Bernese
Bosnian
Chin Maka
Chinese – simplified
Chinese – traditional
Croatian
Czech
Danish
Dari
Dinka
Dutch
Filipino
Finnish
French
German
Greek
Harari
Hazaragi
Hindi
Hmong
Hungarian
Indonesian
Italian
Japanese
Karen
Khmer
Korean
Kurdish (Sorani)
Laotian
Latvian
Lithuanian
Macedonian
Maltese
Nepali
Nuer
Oromo
Persian
Polish
Portuguese
Punjabi
Pushto
Romanian
Russian
Samoan
Serbian
Sinhalese
Slovene
Somali
Spanish
Tagalog
Tamil
Telugu
Thai
Tigrynia
Turkish
Ukrainian
Urdu
Vietnamese
Easy English

Optional INI templates

Supplementary templates

Optional templates

Optional templates record further information on areas relevant to the consumer's circumstances and needs. The templates are designed to assist in broad-based screening and needs identification – they are not diagnostic or assessment tools.

Completing the templates is optional. How your service uses the templates will depend on the policies and procedures of the service and any local protocols or agreements between referral services.

Service providers should use their professional judgement when using the templates. Not all optional templates will be relevant for every consumer, and some items within a template may not be required. This means that it may be appropriate to complete a template only partially.

Optional templates	Description
Single page screener for health and social needs	A screening tool used to identify a consumer's broad health and social needs
Need for assistance with activities of daily living	Functional needs, such as domestic, personal, mobility, transport, vision, communication, behaviour, cognition
Accommodation and safety arrangements	Accommodation, homelessness, family violence, personal emergency plans
Health and chronic conditions	Overall health, chronic conditions, falls, nutritional risk, vision and advance care planning
Social and emotional wellbeing	Personal and social support, mental health and wellbeing
Care relationship, family and social network,	Carers and care recipients; family and social network, including children, young people, parents, guardians, friends and significant others; current pregnancy supports
Alcohol, smoking and substance involvement screening (ASSIST)	Screening tool to identify issues relating to alcohol, smoking or substance use

For **initial needs identification**, only complete those templates relevant to the consumer's issues and needs.

For **referral**, send the core referral templates and the optional templates relevant to the consumer's needs. Additional or supplementary information can be sent as an attachment to the referral.

If your service has completed a detailed assessment of the consumer, send either a copy of the assessment or an assessment summary as an attachment to the core referral templates instead of, or in addition to, the templates.

Single page screener for health and social needs

Service provider administered

Single page screener of health and social needs

Service provider administered

Purpose: to assist service providers to screen for consumer's needs.

Consumer

Name:

Date of Birth: dd/mm/yyyy / /

Sex:

UR Number:

or affix label here

Suggested introduction for consumers

The purpose of these questions is to help us get to know you and provide you with the best possible service.

Your participation in answering these questions is voluntary and we treat your information in the strictest confidence, in accordance with privacy legislation.

If you would like to proceed, we will read out several questions about the kinds of things that may be problems/issues for people.

Please answer '**yes**' or '**no**' to each question.

If you answer '**yes**' to a question we will then ask you whether you would like to discuss it further.

Before we start the questions, may I ask you: what is the main reason you are seeking assistance today?

Questions	**Is this an issue?** Code: ☐	**Would you like to discuss this?** Code: ☐	**If yes, consider completing optional SCTT templates as relevant including those listed below** *For items marked with an asterisks (*) refer to SCTT 2012 User Guide for more information*
Do you have difficulty with daily tasks (such as getting dressed, showering or preparing meals)?			*Need for assistance with activities of daily living Care relationship, family and social network*
Have you been told by a doctor or other health professional that you have a health condition (eg breathing problems, a cancer, heart problems, chronic kidney disease, diabetes, high blood pressure, arthritis, osteoporosis or other condition)?			*Health and chronic conditions*
Have you recently had problems with your teeth, mouth, gums or dentures?			*Health and chronic conditions*
Are you concerned about your medications?			*Health and chronic conditions*
Are you concerned about your lack of physical activity?			*Health and chronic conditions*
Are you concerned about your weight?			*Health and chronic conditions*
Have you recently lost weight without trying?			*Health and chronic conditions*
Do currently smoke tobacco?			*ASSIST*
Have you quit smoking tobacco in the last 5 years?			*ASSIST*
Are you concerned about how much alcohol you drink?			*ASSIST*
Are you concerned about your use of drugs?			*ASSIST*
Are you concerned about your gambling?			*
Is your financial situation very difficult?			*
Do you often feel sad or depressed?			*Social and emotional wellbeing and care relationship, family and social network*
Do you often feel nervous or anxious?			*Social and emotional wellbeing*
Have you felt afraid of someone who controls or hurts you?			*Accommodation and safety arrangements Care relationship, family and social network*
Are you homeless or at risk of homelessness?			*Accommodation and safety arrangements Care relationship, family and social network*
Would you rate your health as poor?			*Health and chronic conditions*
Would you rate your life circumstances as poor?			*

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Page 1 of 1

This information collected by:

Name: Position/Agency:

Sign: Date: dd/mm/yyyy / / Contact number:

Single page screener of health and social needs *Service provider administered*

There are no specific optional templates for these items. However, consider that these items commonly have associated issues and that there may be relevant optional templates.

This question is to pick up on any social issues that may not be captured in the questions above.

The purpose of the *Single page screener for health and social needs* is to support the service provider undertaking initial needs identification to screen for health and social risk and determine the need for further action. In consultation with the consumer, further action may include:

- completion of relevant optional/supplementary templates
- referral to appropriate services
- assessment.

How and when this template is used will depend on the service provider's setting, processes and consumer group.

The service provider may complete this template after discussion with the consumer via the telephone or in person.

If the consumer is to complete the survey, use the version of the *Single page screener for health and social needs – consumer administered* (page 24).

Single page screener for health and social needs

Consumer administered

Single page screener of health and social needs

Consumer administered

Purpose: to assist service providers to screen for a consumer's needs.

Consumer

Name:

Date of Birth: dd/mm/yyyy / /

Sex:

UR Number:

or affix label here

Please complete the following details to help us get to know you and provide you with the best possible service.

Your participation in completing this questionnaire is voluntary, and we treat your information in the strictest confidence, in accordance with privacy legislation.

What is the main reason you are here today?

The following statements are examples of things that may be problems/issues for people**. Please tick any of the statements which apply to you, and tick any items you would like to discuss.** Ignore any statements that do not apply to you. Give the completed form to your service provider at the start of your appointment.

Question	(tick✓)	I would like to discuss this (tick ✓)
I have difficulty with daily tasks (such as getting dressed, showering or preparing meals).	☐	☐
I have been told by a doctor or other health professional that I have a health condition (for example arthritis, high blood pressure, diabetes, heart disease, a cancer, osteoporosis, asthma, lung disease, chronic kidney disease or other condition).	☐	☐
I have recently had problems with my teeth, mouth, gums or dentures.	☐	☐
I am concerned about my medications.	☐	☐
I am concerned about my lack of physical activity.	☐	☐
I am concerned about my weight.	☐	☐
I have recently lost weight without trying.	☐	☐
I currently smoke tobacco.	☐	☐
I have quit smoking tobacco in the last 5 years.	☐	☐
I am concerned about how much alcohol I drink.	☐	☐
I am concerned about my use of drugs.	☐	☐
I am concerned about my gambling.	☐	☐
My financial situation is very difficult.	☐	☐
I often feel sad or depressed.	☐	☐
I often feel nervous or anxious.	☐	☐
I have felt afraid of someone who controls or hurts me.	☐	☐
I am homeless or at risk of homelessness.	☐	☐
I would rate my health as poor.	☐	☐
I would rate my life circumstances as poor.	☐	☐

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This information collected by:

Name: Position/Agency:

Sign: Date: dd/mm/yyyy / / Contact number:

Single page screener for health and social needs

Action guidelines

When the consumer identifies an issue and wishes to discuss it

The general approach involves discussing the issues identified with the consumer and then completing the relevant optional SCTT template(s) and/or referring the consumer for an assessment. Use the following steps as a conversational guideline with the consumer.

Conversation – questions	Action guideline
I note you have indicated [item]. What is your concern?	Briefly discuss the consumer's concern.
Are you receiving any assistance for this?	Briefly discuss whether the consumer is receiving any formal or informal (family) assistance. If they are receiving assistance, check with the consumer that they are happy with how this matter is being managed. If they are not receiving assistance, proceed with following questions.
May I ask you some additional questions?	Use the relevant SCTT optional templates. See *Single page screener for health and social needs – service provider administered* for suggested templates.
Would you like a referral to [service] for assistance with this?	Use the SCTT core referral templates and the relevant optional templates to make referral.

When the consumer identifies an issue and does not wish to discuss it

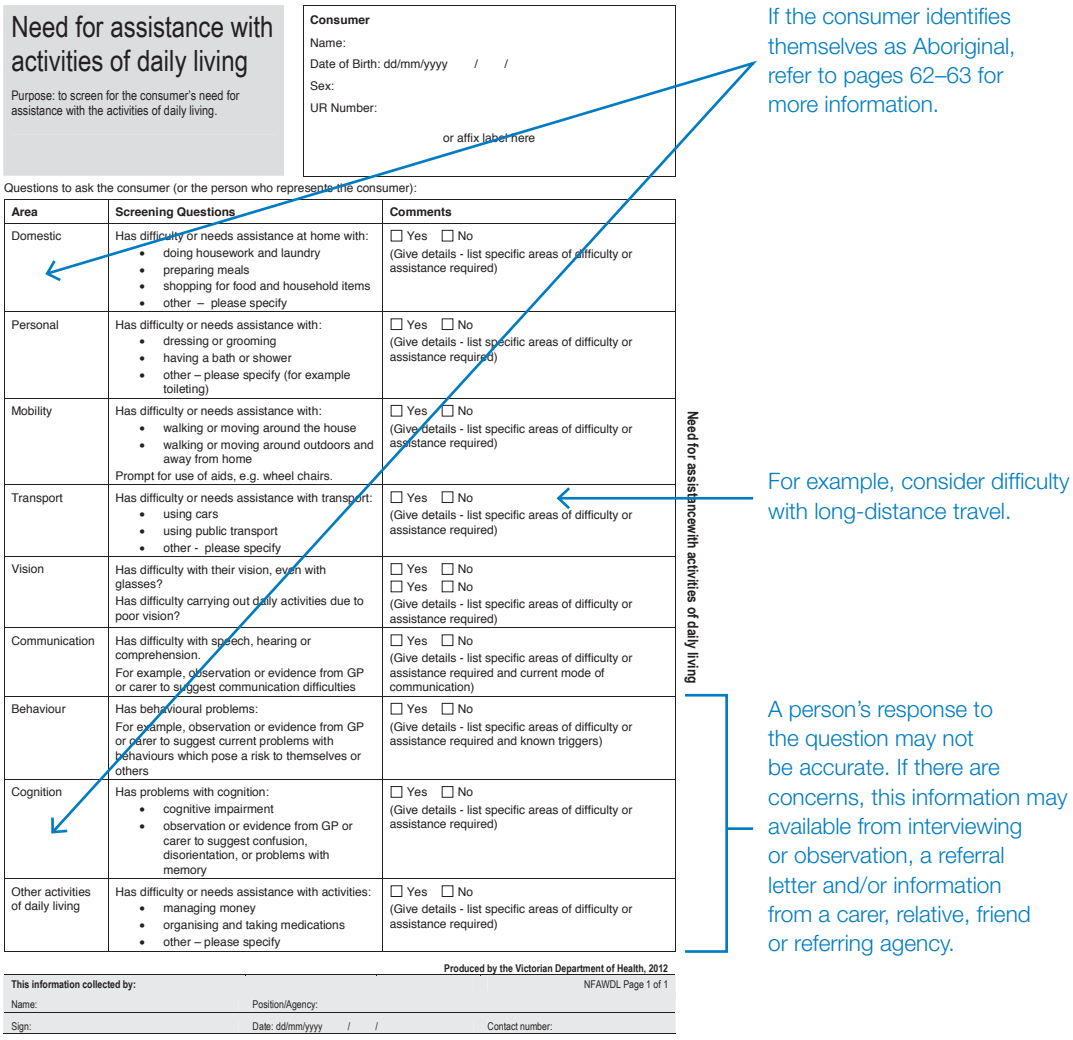
The general approach involves confirming with the consumer that they do not want assistance at this time.

Offer the consumer contact details for services, as relevant.

Use the following steps as a conversational guideline with the consumer.

Conversation	Action guideline
I note you have indicated [item] but do not wish to discuss it today.	Note on consumer record. Offer written information to consider in the future, if appropriate. The service provider may raise the issue again at a future date.
Please feel free to raise it with any service provider in the future should you require assistance or would like contact details for a support service.	

Need for assistance with activities of daily living



Need for assistance with activities of daily living

Purpose: to screen for the consumer's need for assistance with the activities of daily living.

Consumer

Name:

Date of Birth: dd/mm/yyyy / /

Sex:

UR Number:

or affix label here

Questions to ask the consumer (or the person who represents the consumer):

Area	Screening Questions	Comments
Domestic	Has difficulty or needs assistance at home with: • doing housework and laundry • preparing meals • shopping for food and household items • other – please specify	☐ Yes ☐ No (Give details - list specific areas of difficulty or assistance required)
Personal	Has difficulty or needs assistance with: • dressing or grooming • having a bath or shower • other – please specify (for example toileting)	☐ Yes ☐ No (Give details - list specific areas of difficulty or assistance required)
Mobility	Has difficulty or needs assistance with: • walking or moving around the house • walking or moving around outdoors and away from home Prompt for use of aids, e.g. wheel chairs.	☐ Yes ☐ No (Give details - list specific areas of difficulty or assistance required)
Transport	Has difficulty or needs assistance with transport: • using cars • using public transport • other - please specify	☐ Yes ☐ No (Give details - list specific areas of difficulty or assistance required)
Vision	Has difficulty with their vision, even with glasses? Has difficulty carrying out daily activities due to poor vision?	☐ Yes ☐ No ☐ Yes ☐ No (Give details - list specific areas of difficulty or assistance required)
Communication	Has difficulty with speech, hearing or comprehension. For example, observation or evidence from GP or carer to suggest communication difficulties	☐ Yes ☐ No (Give details - list specific areas of difficulty or assistance required and current mode of communication)
Behaviour	Has behavioural problems: For example, observation or evidence from GP or carer to suggest current problems with behaviours which pose a risk to themselves or others	☐ Yes ☐ No (Give details - list specific areas of difficulty or assistance required and known triggers)
Cognition	Has problems with cognition: • cognitive impairment • observation or evidence from GP or carer to suggest confusion, disorientation, or problems with memory	☐ Yes ☐ No (Give details - list specific areas of difficulty or assistance required)
Other activities of daily living	Has difficulty or needs assistance with activities: • managing money • organising and taking medications • other – please specify	☐ Yes ☐ No (Give details - list specific areas of difficulty or assistance required)

Need for assistancewith activities of daily living

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This information collected by: NFAWDL Page 1 of 1

Name: Position/Agency:

Sign: Date: dd/mm/yyyy / / Contact number:

If the consumer identifies themselves as Aboriginal, refer to pages 62–63 for more information.

For example, consider difficulty with long-distance travel.

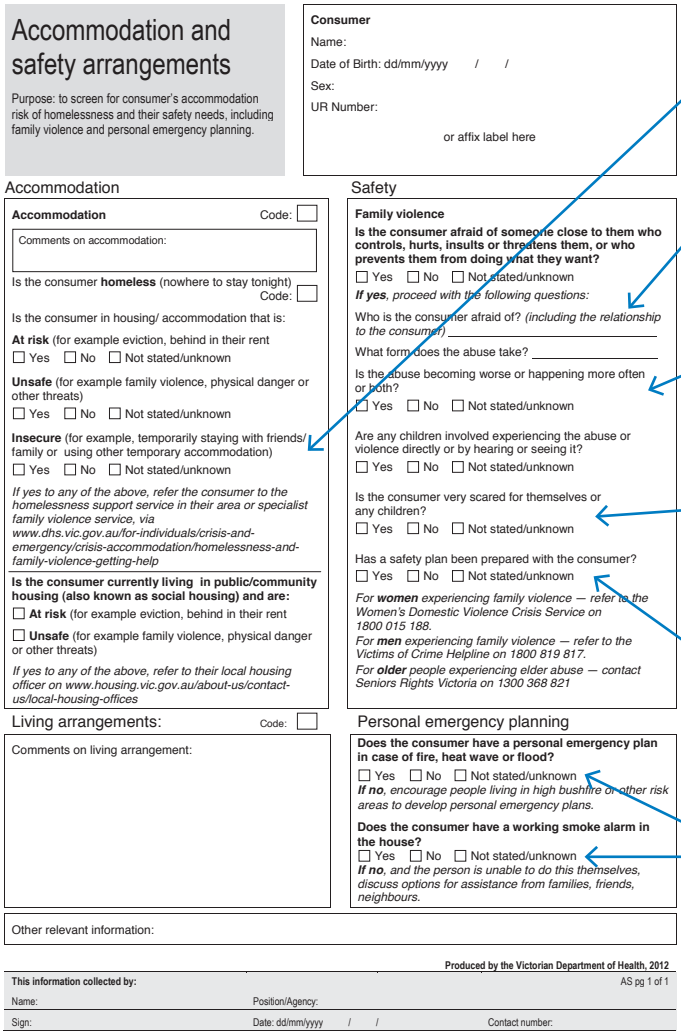
A person's response to the question may not be accurate. If there are concerns, this information may available from interviewing or observation, a referral letter and/or information from a carer, relative, friend or referring agency.

This template screens for broad areas of functional needs, such as domestic, personal, mobility and transport.

This template may be used by programs such as mental health, disability, housing or community health to assist in determining if a consumer needs assistance at home or needs a referral to a Home and Community Care (HACC) assessment service.

The *Need for assistance with activities of daily living* template should not be used for communicating the outcomes of a functional assessment. Agencies that carry out functional assessments (such as HACC, ACAS, the Hospital Admission Risk Program (HARP), Sub-acute Care Services (SACS) and Disability Services) use the *Functional assessment summary* (refer to page 39) to provide a summary of the functional status of the consumer for referral purposes.

Accommodation and safety arrangements



Accommodation and safety arrangements

Purpose: to screen for consumer's accommodation risk of homelessness and their safety needs, including family violence and personal emergency planning.

Consumer

Name:

Date of Birth: dd/mm/yyyy / /

Sex:

UR Number:

or affix label here

Accommodation

Accommodation Code:

Comments on accommodation:

Is the consumer **homeless** (nowhere to stay tonight) Code:

Is the consumer in housing/ accommodation that is:

At risk (for example eviction, behind in their rent
☐ Yes ☐ No ☐ Not stated/unknown

Unsafe (for example family violence, physical danger or other threats)
☐ Yes ☐ No ☐ Not stated/unknown

Insecure (for example, temporarily staying with friends/ family or using other temporary accommodation)
☐ Yes ☐ No ☐ Not stated/unknown

If yes to any of the above, refer the consumer to the homelessness support service in their area or specialist family violence service, via www.dhs.vic.gov.au/for-individuals/crisis-and-emergency/crisis-accommodation/homelessness-and-family-violence-getting-help

Is the consumer currently living in public/community housing (also known as social housing) and are:

☐ **At risk** (for example eviction, behind in their rent

☐ **Unsafe** (for example family violence, physical danger or other threats)

If yes to any of the above, refer to their local housing officer on www.housing.vic.gov.au/about-us/contact-us/local-housing-offices

Safety

Family violence

Is the consumer afraid of someone close to them who controls, hurts, insults or threatens them, or who prevents them from doing what they want?
☐ Yes ☐ No ☐ Not stated/unknown

***If yes**, proceed with the following questions:*

Who is the consumer afraid of? *(including the relationship to the consumer)* _____

What form does the abuse take? _____

Is the abuse becoming worse or happening more often or both?
☐ Yes ☐ No ☐ Not stated/unknown

Are any children involved experiencing the abuse or violence directly or by hearing or seeing it?
☐ Yes ☐ No ☐ Not stated/unknown

Is the consumer very scared for themselves or any children?
☐ Yes ☐ No ☐ Not stated/unknown

Has a safety plan been prepared with the consumer?
☐ Yes ☐ No ☐ Not stated/unknown

*For **women** experiencing family violence — refer to the Women's Domestic Violence Crisis Service on 1800 015 188.*
*For **men** experiencing family violence — refer to the Victims of Crime Helpline on 1800 819 817.*
*For **older** people experiencing elder abuse — contact Seniors Rights Victoria on 1300 368 821*

Accommodation and safety arrangements

Living arrangements: Code:

Comments on living arrangement:

Personal emergency planning

Does the consumer have a personal emergency plan in case of fire, heat wave or flood?
☐ Yes ☐ No ☐ Not stated/unknown
***If no**, encourage people living in high bushfire or other risk areas to develop personal emergency plans.*

Does the consumer have a working smoke alarm in the house?
☐ Yes ☐ No ☐ Not stated/unknown
***If no**, and the person is unable to do this themselves, discuss options for assistance from families, friends, neighbours.*

Other relevant information:

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This information collected by: AS pg 1 of 1

Name: Position/Agency:

Sign: Date: dd/mm/yyyy / / Contact number:

For further referral suggestions see page 28.

It is important to identify the relationship between the victim and perpetrator, in order to assess immediate risk and safety considerations.

An escalation in frequency or severity of abuse is a factor that increases the risk of serious injury or death to a consumer.

If yes, then an immediate active referral needs to be undertaken.

A safety plan helps the consumer to identify ways to increase their safety, should they need to leave their home quickly or feel unsafe or in danger. If answer is no, refer to page 29.

If no, refer to page 30.

Accommodation

Consider using this template if the consumer has, or may have, issues or needs related to their accommodation and safety.

Consider completing other optional templates, such as the *Care relationship, family and social network.*

If the person experiences or is at risk of homelessness, refer them to the homelessness support service in their area or specialist family violence service (see <www.dhs.vic.gov.au/for-individuals/crisis-and-emergency/crisis-accommodation/homelessness-and-family-violence-getting-help>).

Definitions of homelessness include:

- sleeping rough (those without shelter): primary homelessness
- stop-gap accommodation (those in crisis, but temporarily sheltered): secondary homelessness
- marginal accommodation (insecure accommodation): tertiary homelessness.

A person who lives in public or long-term community housing may be referred to the local housing office, which is able to assess the person's needs and refer them to the Social Housing Advocacy and Support program, which offers support to establishing and/or at-risk tenancies.

> Public housing refers to housing that is built, operated and owned by government. Long-term community housing is owned by not-for-profit organisations that provide safe, secure, affordable and appropriate rental housing.

As a practitioner/worker, you may need to be aware that a person in supported housing (for example, disability, mental health or aged care accommodation) may have a worker. However, if their tenancy is a risk and you are unable to contact that worker, please refer to one of the entry points documented on the template for assistance.

Safety

Family violence

Family violence can occur in all sectors of the community. The following factors increases the risk of serious injury or death if family violence is occurring:

- pregnancy or the recent birth of a child
- recent separation from a partner or spouse, or being in the process of separation.

Family violence includes behaviour to a family member which is physically, sexually, emotionally or economically abusive, or controls or dominates a person in a way which causes them to feel fear for the safety of themselves or another family member.

It is not just direct experience of family violence that affects children. Children also experience violence by hearing events or witnessing violence or its effects, or they may live in fear due to a violent environment. Where children are involved, there are two elements to consider: the child's safety, and the child's wellbeing.

If there are concerns of direct harm occurring to a child, the service provider should make an immediate report to child protection (see <http://www.cyf.vic.gov.au/family-services/to-make-a-report-to-child-protection>). If there are significant concerns for the child's wellbeing, the service provider should make a referral to Child FIRST (see <http://www.cyf.vic.gov.au/every-child-every-chance/how-to-make-a-referral-to-child-first>).

Organisations should have systems and guidelines in place to respond to situations where family violence has been identified. For more information on safety plans refer to: <www.dpcd.vic.gov.au/women/>.

Safety and older persons

If the person is over 65 years old (or over 45 if an Aboriginal person), and there are concerns for their safety but the threat is not immediate, refer to your organisation's elder abuse prevention policy for appropriate action. See *With Respect to Age – 2009* at: <http://www.health.vic.gov.au/agedcare/publications/respect/>).

If your organisation does not have an elder abuse policy or requires more information, contact Senior Rights Victoria on 1300 368 821 or go to <http://www.seniorsrights.org.au/> for advice. If the older person's safety is at immediate risk contact Victoria Police, Ambulance or Fire Brigade on 000.

Personal emergency planning

People who live in high risk areas (eg flood,fire) need to be given information about how to make a personal emergency plan. It is expected that people will take action on their own behalf or link into family, friends or neighbours who may assist them to make a personal emergency plan and provide assistance in an emergency. For all hazard planning tools see the following websites:

- Red Cross Resources: <www.redcross.org.au/emergency-resources.aspx>
- bushfire plans – leaving early: <http://www.redcross.org.au/files/Bushfires_preparing_to_leave_early_editable.pdf>
- CFA resources/kits: <www.cfa.vic.gov.au/firesafety/bushfire/firereadykit.htm>.

If the consumer does not have a working smoke alarm, prompt them to get a smoke alarm installed and check their batteries annually. The Melbourne Fire Brigade (MFB) recommends stand-alone photoelectric alarms with a 10-year battery. Seek further advice on selection, installation and maintenance, or see: <www.mfb.vic.gov.au/community-safety.html> for training resources.

Health and chronic conditions

Page 1

Health and chronic conditions

Purpose:to assist service providers to screen for health and chronic conditions

Consumer
Name:
Date of Birth: dd/mm/yyyy / /
Sex:
UR Number:
or affix label here

General health and health literacy

Health literacy Do you have difficulty understanding information, instructions or written material you receive from your doctor or other health professionals?	Code: ☐
General health In general, you would say your health is:	Code: ☐
Self-care What do you do to take care of yourself and your health?	
Main concerns What do you see as your main health and wellbeing concerns or issues?	
Making changes Have you thought about making changes to improve your health and wellbeing?	☐ Yes ☐ No ☐ Not stated/unknown
GP check-ups Have you had check-ups with your GP in the last 12 months?	☐ Yes ☐ No ☐ Not stated/unknown ☐ Don't have a GP
Eye checks When did you last have your eyes checked?	
Hearing How is your hearing (with your hearing aid)?	Code: ☐

Health and chronic conditions

Have you ever been told by a doctor or nurse that you have the following conditions?

☐	**Breathing** problems (Respiratory condition For example asthma, shortness of breath)	☐	**Diabetes**
☐	**Cancer** If yes, state type:	☐	**High blood pressure** (hypertension)
☐	**Heart** problems (cardiovascular or heart disease)	☐	**Arthritis, osteoporosis** (musculoskeletal conditions)
☐	Chronic **kidney** disease	☐	**Stroke, Parkinson's disease, multiple sclerosis** or other neurological disorders
Other and/or comments:			

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This information collected by: HCC Page 1 of 2

Name: Position/Agency:

Sign: Date: dd/mm/yyyy / / Contact number:

Health and chronic conditions

If sometimes/often/always, the consumer should be asked who normally helps them and whether they would like any information explained. The referral service needs to be aware of the person's health literacy needs so they can tailor interventions to meet these needs.

If the consumer has difficulty in responding to this question, consider using appropriate prompts, for example, 'Do you do any physical activity?'

This question can be followed by a discussion about whether the consumer is interested in making any changes and/or the type of changes that may be considered.

Regular follow-up every two years. Regular follow-up should occur every 12 months if consumer has any of the following characteristics:

- a family history of eye disease
- diabetes
- aged over 40
- Aboriginal or Torres Strait Islander descent
- noticed a change in vision.

If the consumer identifies as Aboriginal please refer to page 63 for more information.

If health or chronic condition identified:

- Do they have a current management plan for the condition? (for example, clinical plan, self-management plan, GP management plan)
- Do they follow the plan?
- If they do not have a management plan, would they like any follow-up assistance? Discuss referral and assessment options.
- If they are unsure if they have a chronic condition, request an assessor to explore further.

Health and chronic conditions

Page 2

Health and chronic conditions

Purpose:to assist service providers to screen for health and chronic conditions

Consumer
Name:
Date of Birth: dd/mm/yyyy / /
Sex:
UR Number:
or affix label here

Falls risk

Have you had any falls in or around your home in the past 12 months?	☐ Yes ☐ No ☐ Not stated/unknown

Pain

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

Physical activity

In the past week, on how many days have you done a total of 30 minutes or more of physical activity, which was enough to raise your breathing rate?	

Nutritional risk

☐ Obvious underweight – frailty?	☐ Frequent chest infections?
☐ **Unintentional** weight loss?	☐ Follows a special diet?
☐ Obvious overweight affecting life quality?	☐ Needs assistance to shop for food, prepare food or to feed themselves?
☐ Unintentional weight gain?	☐ Has the consumer had any recent changes in circumstances that have affected what they eat, how they prepare meals or how they shop?
☐ Reduced appetite or reduced food and fluid intake?	☐ Are there concerns about the client's ability to have an adequate diet?
☐ Mouth or teeth problem?	☐ No risk identified
☐ Chewing or swallowing problem? (eg choking or coughing during/after meals)?	

Social isolation

How often do you feel isolated from others?	Code: ☐

Advance Care Planning

Does the consumer have an Advance Care Plan?	☐ Yes ☐ No ☐ Not stated/unknown If yes, where is it kept?
Does this include a Refusal of Treatment Certificate or other documentation limiting treatment?	☐ Yes ☐ No ☐ Not stated/unknown
Does the consumer have a nominated substitute decision maker (enduring power of attorney medical treatment) in relation to medical decisions?	☐ Yes ☐ No ☐ Not stated/unknown If yes, name of substitute decision maker?

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This information collected by: HCC Page 2 of 2

Name: Position/Agency:
Sign: Date (dd/mm/yyyy) / / Contact number:

Health and chronic conditions

If yes, consider referral for specialist assessment (for example, falls prevention program, physiotherapist, occupational therapist).

If the consumer does less than 30 minutes physical activity three times per week, consider asking if they would like information on the importance of physical activity for their overall health, and/or to be referred to a service to support them to increase their physical activity.

May indicate problems with swallowing, for example, neurological disorders.

If sometimes or always, consider completing the *Care relationship, family and social network* and the *Accommodation and safety arrangements* templates.

For more information see page 33.

At the time of publication, the Advance Care Planning (ACP) Implementation Strategy has not been released. See <health.vic.gov.au/acp> for ACP updated resources and links.

ACP is the process of planning for a person's future health and personal care. It helps ensure that an individual's choices are respected for future medical treatment. Their beliefs, values and preferences are made known in order to guide future care, should the person be unable to make decisions or communicate. There are two main aspects to ACP:

- appointing a **substitute decision maker**. In Victoria this is best done by appointing an enduring power of attorney (medical treatment)
  and/or
- discussing and documenting a person's wishes for care. Documentation of values, beliefs and preferences can provide clarity to the treating medical team.

ACP can be formal or informal, written or verbal, undertaken by a specialised health professional or by the person independently in their own environment. When a person has an ACP it is preferable that the health service holds a copy, because this improves the likelihood that the ACP will be seen and considered. It is also recommended that the person and their substitute decision maker (if applicable) also have a copy.

Social and emotional wellbeing

Social and emotional wellbeing

Purpose: to screen for consumer's social and emotional wellbeing needs, including anxiety and depression.

Consumer

Name:

Date of Birth: dd/mm/yyyy / /

Sex:

UR Number:

or affix label here

Personal and social support

During the past 4 weeks, was someone available to help you if you needed and wanted help? _____ Code: ☐

For example if you: felt very nervous, lonely or sad, 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.

Comment on personal and social support, including social isolation, family and personal relationships, and friendship groups

Consider using the *Care relationship, family and social network* template to document the family and social network, especially in cases involving vulnerable consumers.

If the consumer identifies themselves as Aboriginal, refer to page 64 for more information.

Kessler psychological distress scale (K10)

Screening for anxiety and depression

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

K10 Scale		All of the time **5**	Most of the time **4**	Some of the time **3**	A little of the time **2**	None of the time **1**
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?	☐	☐	☐	☐	☐

Total K-10 Score: ☐

Score of 20 and above – Consider referral for mental health assessment by a GP, community health counsellor, or mental health professional (eg psychologist or psychiatrist)

If you think the person may have a serious mental illness and/or be at risk of self harm, seek advice about the need for referral from the triage clinician at the public specialist mental health services applicable to your area.

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This information collected by:

Name: Position/Agency:

Sign: Date: dd/mm/yyyy / / Contact number:

Consider using this template if the consumer has, or may have, issues and needs for personal and social support, family and personal relationships and/mental health and wellbeing.

K10 is a validated scale used to yield a global measure of psychological distress for individuals who have the capacity to self-report. Alternative scales may be available for individuals who do not have the capacity to self-report.

Questions on the scale should be read to the consumer, and the response recorded (Questions 3 and 6 should not be asked if the person answered 'None of the time' to the previous question). The total is recorded at the bottom of the scale.

Anxiety, panic attack, stress and/or depression or stress-related illnesses may be possible indicators of family violence. Depression or mental health issues may also increase the vulnerability of a consumer who is experiencing family violence. Consult the *Family violence risk assessment and risk management framework* for further information about indicators of family violence, risk factors and risk assessment at: <www.women.vic.gov.au>.

Psychosocial profile categories are based on the *Victorian Population Health Survey* standards in line with the Transport Accident Commission and WorkCover application of K10.

Care relationship, family and social network

Care relationship, family and social network

Purpose: to assist service providers to understand care relationships and family and support networks such as friends and significant others who are involved in the consumer's life.

Consumer

Name:

Date of Birth: dd/mm/yyyy / /

Sex:

UR Number:

or affix label here

Care relationship *(carer or care recipient)*

Name	M or F	Date of birth *(or age in years)*	Relationship to consumer Code:	Relationship considerations *(strengths and risks)*	Contact details	Employment or student status Code:	Lives in consumer's home Code:	Is there an emergency care plan in place? *Yes/No*

Family and social support *(for example: parents, guardian, children, adolescents, support workers, significant others (other than those in the care relationship)*

Name	M or F	Date of birth *(or age in years)*	Relationship to consumer Code:	Relationship Considerations *(strengths and risks)*	Contact details	Employment or student status Code:	Lives in consumer's home *Yes/No*

Pregnancy and family support

Is the consumer pregnant? ☐ Yes ☐ No ☐ Not stated/unknown

If yes:

Has the consumer accessed or organised antenatal care (private or through a hospital clinic)? _____

Has the consumer organised or booked into the hospital or have a midwife arranged for your birth (in the case of a planned home birth)? _____

If there are other children who will be caring for the consumer's children when the consumer is having the baby?

_____

Produced by the Victorian Department of Health, 2012

This information collected by: CRFSI pg 1 of 1

Name: Position/Agency:

Sign: Date: dd/mm/yyyy / / Contact number:

Care relationship, family and social network

These characteristics may indicate that the person is at increased risk:

- they care for more than one person
- they spend many hours a day in caring role
- they care for people with high support needs.

Record here if the carer is receiving a carer allowance or carer payment. If they are currently not in receipt of allowance or payment, consider exploring their eligibility. Carers may concurrently be employed or studying and still receive an allowance or payment.

An emergency care plan stipulates alternative arrangements if the carer is unable to care through illness, holidays, incarceration and so on.

Emergency care plans are available from the Commonwealth Respite and Carelink Centre 1800 052 222.

Record the relationship considerations of the person, for example: level of contact, confidante, support, family court order or intervention order, abuse/violence, registered contact for personal alarm.

List primary contact first.

This template identifies the family and social support a person has, which is important for vulnerable consumers (such as children, older people, people who experience or are at risk of homelessness). Links include:

- Carers Victoria Advisory Line: 1800 242 636 (www.carersvic.org.au)
- Commonwealth Respite and Carelink Centres: 1800 052 222 (www.respiteseeker.com.au)
- Aged Care in Victoria: <www.health.vic.gov.au/agedcare/services/carers>.

Family and social network

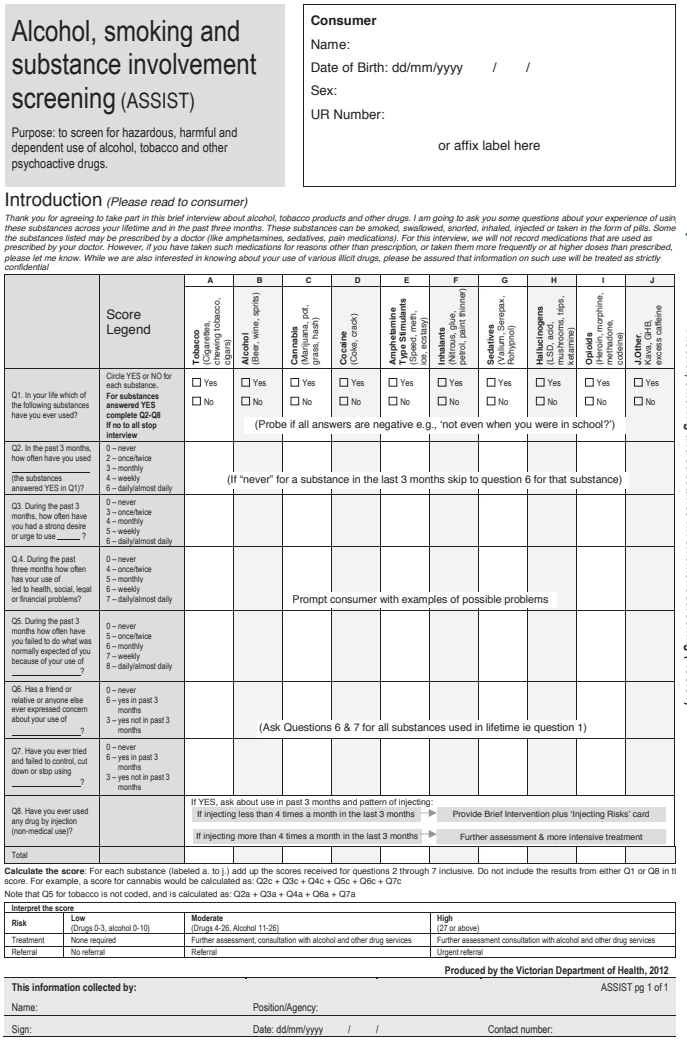
When recording a consumer's family, social or medical history, a person employed by a health service (see the definition under definitions) may collect certain health information about a person, other than the consumer, to assist in providing them with other health services without that person's consent, according to the *Health Records Act 2001.*

If a person who is **not** within a health service collects personal information about an individual from someone else, they must take **reasonable steps** to ensure that the individual is made aware of who, why and what information is collected and who the information will be shared with. The exception to this is the extent that making the individual aware of the matters would pose a serious threat to the life or health of any individual. For more specific and comprehensive details refer to the *Privacy Act 1988* and the policy of your agency.

Consider the cultural background of the person, and how this may affect their view and understanding of their family and social network.

Aboriginal people have a complex system of family relations in the local community. The connection to 'immediate family' is expanded to include siblings (brothers/sisters), uncles, aunts, cousins and grandparents. In some Aboriginal communities it is an accepted cultural custom that a younger member of the community refers to adults as 'uncle' or 'aunty' as a sign of respect. This does not mean that people are related. For further information, refer to page 66.

Alcohol, smoking and substance involvement screening (ASSIST)



Alcohol, smoking and substance involvement screening (ASSIST)

Purpose: to screen for hazardous, harmful and dependent use of alcohol, tobacco and other psychoactive drugs.

Consumer

Name:

Date of Birth: dd/mm/yyyy / /

Sex:

UR Number:

or affix label here

Introduction *(Please read to consumer)*

Thank you for agreeing to take part in this brief interview about alcohol, tobacco products and other drugs. I am going to ask you some questions about your experience of usin these substances across your lifetime and in the past three months. These substances can be smoked, swallowed, snorted, inhaled, injected or taken in the form of pills. Some the substances listed may be prescribed by a doctor (like amphetamines, sedatives, pain medications). For this interview, we will not record medications that are used as prescribed by your doctor. However, if you have taken such medications for reasons other than prescription, or taken them more frequently or at higher doses than prescribed, please let me know. While we are also interested in knowing about your use of various illicit drugs, please be assured that information on such use will be treated as strictly confidential

Prior to the administration of ASSIST, the consumer needs to be read this introduction.

	Score Legend	A	B	C	D	E	F	G	H	I	J
		Tobacco (Cigarettes, chewing tobacco, cigars)	**Alcohol** (Beer, wine, spirits)	**Cannabis** (Marijuana, pot, grass, hash)	**Cocaine** (Coke, crack)	**Amphetamine Type Stimulants** (Speed, meth, ice, ecstasy)	**Inhalants** (Nitrous, glue, petrol, paint thinner)	**Sedatives** (Valium, Serepax, Rohypnol)	**Hallucinogens** (LSD, acid, mushrooms, tabs, ketamine)	**Opioids** (Heroin, morphine, methadone, codeine)	**J.Other** Ketes, GHB, khat, caffeine
Q1. In your life which of the following substances have you ever used?	Circle YES or NO for each substance. **For substances answered YES complete Q2-Q8 If no to all stop interview**	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
		(Probe if all answers are negative e.g., 'not even when you were in school?')									
Q2. In the past 3 months, how often have you used _____ (the substances answered YES in Q1)?	0 – never 2 – once/twice 3 – monthly 4 – weekly 6 – daily/almost daily	(If "never" for a substance in the last 3 months skip to question 6 for that substance)									
Q3. During the past 3 months, how often have you had a strong desire or urge to use _____ ?	0 – never 3 – once/twice 4 – monthly 5 – weekly 6 – daily/almost daily										
Q.4. During the past three months how often has your use of led to health, social, legal or financial problems?	0 – never 4 – once/twice 5 – monthly 6 – weekly 7 – daily/almost daily	Prompt consumer with examples of possible problems									
Q5. During the past 3 months how often have you failed to do what was normally expected of you because of your use of _____ ?	0 – never 5 – once/twice 6 – monthly 7 – weekly 8 – daily/almost daily										
Q6. Has a friend or relative or anyone else ever expressed concern about your use of _____ ?	0 – never 6 – yes in past 3 months 3 – yes not in past 3 months	(Ask Questions 6 & 7 for all substances used in lifetime ie question 1)									
Q7. Have you ever tried and failed to control, cut down or stop using _____ ?	0 – never 6 – yes in past 3 months 3 – yes not in past 3 months										
Q8. Have you ever used any drug by injection (non-medical use)?		If YES, ask about use in past 3 months and pattern of injecting: If injecting less than 4 times a month in the last 3 months → Provide Brief Intervention plus 'Injecting Risks' card If injecting more than 4 times a month in the last 3 months → Further assessment & more intensive treatment									
Total											

Calculate the score: For each substance (labeled a. to j.) add up the scores received for questions 2 through 7 inclusive. Do not include the results from either Q1 or Q8 in th score. For example, a score for cannabis would be calculated as: Q2c + Q3c + Q4c + Q5c + Q6c + Q7c

Note that Q5 for tobacco is not coded, and is calculated as: Q2a + Q3a + Q4a + Q6a + Q7a

Interpret the score			
Risk	**Low** (Drugs 0-3, alcohol 0-10)	**Moderate** (Drugs 4-26, Alcohol 11-26)	**High** (27 or above)
Treatment	None required	Further assessment, consultation with alcohol and other drug services	Further assessment consultation with alcohol and other drug services
Referral	No referral	Referral	Urgent referral

Produced by the Victorian Department of Health, 2012

This information collected by: ASSIST pg 1 of 1

Name: Position/Agency:

Sign: Date: dd/mm/yyyy / / Contact number:

Alcohol, smoking and substance involvement screening (ASSIST)

The alcohol, smoking and substance involvement screening is a brief screening questionnaire to find out about people's use of psychoactive substances. It was developed by the World Health Organisation as a method of screening for hazardous, harmful and dependent use of alcohol, tobacco and other psychoactive drugs.

The ASSIST screening tool is one of several screening tools chosen by mental health services (clinical and PDRSS) for use with their consumers, with the aim of early intervention and appropriate treatment for individuals with a dual diagnosis.

ASSIST can be self-administered or clinician administered in a private setting.

Further information about individual drugs, resources for clients and referral sources can be found on the Drug Info website at: <www.druginfo.adf.org.au>.

Supplementary templates

Functional assessment summary

Page 1

Functional Assessment Summary

This supplementary template is sent with referrals that occur following assessment of the consumer's functional abilities and need for assistance.
The assessing agency may attach additional assessment summaries covering other domains of consumer relevant to the referral.

Consumer

Name:

Date of Birth: dd/mm/yyyy / /

Sex:

UR Number:

or affix label here

Rating of Functional Abilities

- Tick one response for each activity (example: housework, transport, shopping etc.)
- Rate what the person is currently capable of doing rather than what they actually do. In addressing capability for any item, 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 or challenging behaviour). Consumers who can only complete a task with verbal prompting should *not* be rated as independent.
- If unable to rate an activity, leave it blank.

Notes: Use the notes section to describe client's specific need for assistance as well as other factors impacting on level and type of need for example. use of aids and equipment/home modifications; assistance provided by carers/other agencies.

Activity	Rating (✓ one)	Domestic care
1. Housework	☐	Can maintain house without help or supervision (including laundry)
	☐	Needs some help or supervision
	☐	Completely unable to do housework
2. Transport	☐	Without help (drives own car, travels independently on public transport or taxis)
	☐	With some help (need someone to help or accompany when traveling)
	☐	Completely unable to travel (unless arrangements are made for a specialized vehicle like an ambulance)
3. Shopping (assuming client has transport)	☐	Can take care of all shopping needs
	☐	With some help (need someone to go with client on all shopping trips)
	☐	Completely unable to do any shopping
4. Meal Preparation	☐	Without help (including planning/preparing/cooking, adequacy of meals and serving)
	☐	With some help
	☐	Completely unable to do any meal preparation, serving or manage nutrition
5. Taking Medications	☐	Without help (in the right doses at the right time)
	☐	With some help (e.g. if someone prepares or reminds client)
	☐	Completely unable to take own medicines without help
6. Handling Money	☐	Without help (writing cheques, paying bills, banking, keeping track of finances)
	☐	With some help (manage day-to-day buying but need help with chequebook and paying bills)
	☐	Completely unable to handle money
7. Telephone	☐	Without help (making and receiving phone calls & incl use of assistive devices)
	☐	With some help
	☐	Completely unable to use the telephone
8. Mobility/ Walking	☐	Without help, except for the use of a cane
	☐	With some help from a person (physical or verbal), or with the use of a walker or crutches. If in a wheelchair, tick this rating if the person manages independently including cornering.
	☐	Completely unable to walk. If in a wheelchair, tick this rating if the person is not independent but must be pushed.
9. Mobility: bed/chair transfers	☐	No help needed
	☐	Needs some help
	☐	Unable to manage – no sitting balance

Assessment notes – Domestic care (In relation to table on page 1):

Produced by the Victorian Department of Health, 2012

This information collected by: Supplementary Form Page 1 of 2

Name: Position/Agency:

Sign: Date: dd/mm/yyyy / / Contact number:

Functional assessment summary

The *Functional assessment summary* template is appropriate for use by any agency that conducts assessments of consumers' functional ability (for example, HACC, ACAS, Disability Services, HARP and SACS programs).

The items of this template map to the HACC MDS version 2 functional status data items.

The *Functional assessment summary* is not an assessment tool, but is used to transfer assessment-level information after a face-to-face assessment of the functional status of the consumer.

This is a supplementary template and should not be filled out at intake.

A service that conducts functional assessments will use program-specific tools or validated tools.

Functional assessment summary

Page 2

Functional Assessment Summary

This supplementary template is sent with referrals that occur following assessment of the consumer's functional abilities and need for assistance.
The assessing agency may attach additional assessment summaries covering other domains of consumer relevant to the referral.

Consumer

Name:

Date of Birth: dd/mm/yyyy / /

Sex:

UR Number:

or affix label here

Activity	Rating (✓ one)	Personal Care
10. Self-care screening question	Does the client need assistance with any areas of personal care/self care, such as bathing, dressing, eating toileting, managing incontinence?	
	☐	No (go to Q16)
	☐	Yes (continue with questions below)
11. Bathing	☐	Without help (include in and out of shower or bath and washing unsupervised)
	☐	With some help (for example. need help getting in or out of the bath)
	☐	Completely unable to bathe without help
12. Dressing	☐	Without help (including buttons, zips, laces)
	☐	With some help (for example. help with buttons etc. but can put on some garments alone)
	☐	Completely unable to dress
13. Eating	☐	Without help
	☐	With some help (for example. help cutting up food, spreading butter, pouring drink)
	☐	Completely unable to eat without help (for example. spoon feeding)
14. Toilet use	☐	Without help (includes on and off, dressing and cleans self)
	☐	With some help
	☐	Completely unable to manage toileting without help
15. Continence (bowels and/or bladder)	☐	Completely continent including self management of catheter or ostomy. Rate based on last week.
	☐	Occasional incontinence (less than once per day)
	☐	Incontinent (no control or daily episodes of incontinence)
Assessment notes – Personal Care/Self Care:		

Activity	Rating (✓ one)	Communication, cognition & behaviour
16. Communication (Need for assistance with understanding or making oneself understood others)	☐	No assistance required including independent use of aids and equipment such as hearing aids or speech aids. Do not indicate use of interpreters here.
	☐	Some assistance required (for example. if person sometimes or often misses the speaker's intent, or needs prompting to find words or finish sentences.)
	☐	Assistance always required
Assessment notes – Communication:		
17. Memory problems or confusion	☐	No
	☐	Yes
18. Behavioural problems	☐	No
	☐	Yes (for example. aggression, wandering or agitation)
Assessment notes – cognition and behaviour:		

Assessment details

Date of assessment (dd/mm/yyyy): / / Assessor name:

Other comments, for example. assessment tools used, location of assessment, other assessment summaries attached:

Produced by the Victorian Department of Health, 2012

This information collected by: Supplementary Form Page 2 of 2

Name: Position/Agency:

Sign: Date: dd/mm/yyyy / / Contact number:

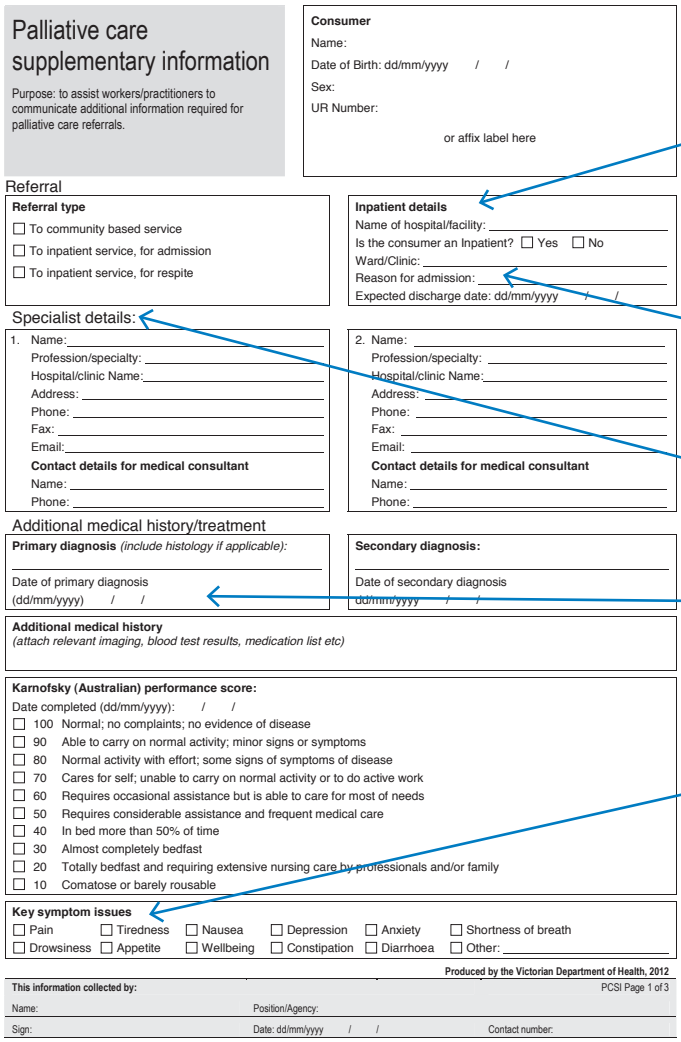
Functional assessment summary

This is a supplementary template.

If this template is included in a referral, it is not necessary to send the *Need for assistance with activities of daily living* template.

Palliative care supplementary information

Page 1



Palliative care supplementary information

Purpose: to assist workers/practitioners to communicate additional information required for palliative care referrals.

Consumer
Name:
Date of Birth: dd/mm/yyyy / /
Sex:
UR Number:
or affix label here

Referral

Referral type
☐ To community based service
☐ To inpatient service, for admission
☐ To inpatient service, for respite

Inpatient details
Name of hospital/facility: _____
Is the consumer an Inpatient? ☐ Yes ☐ No
Ward/Clinic: _____
Reason for admission: _____
Expected discharge date: dd/mm/yyyy / /

Specialist details:

1. Name: _____
Profession/specialty: _____
Hospital/clinic Name: _____
Address: _____
Phone: _____
Fax: _____
Email: _____
Contact details for medical consultant
Name: _____
Phone: _____

2. Name: _____
Profession/specialty: _____
Hospital/clinic Name: _____
Address: _____
Phone: _____
Fax: _____
Email: _____
Contact details for medical consultant
Name: _____
Phone: _____

Additional medical history/treatment

Primary diagnosis *(include histology if applicable):*
_____
Date of primary diagnosis (dd/mm/yyyy) / /

Secondary diagnosis:
_____
Date of secondary diagnosis dd/mm/yyyy / /

Additional medical history
(attach relevant imaging, blood test results, medication list etc)

Karnofsky (Australian) performance score:
Date completed (dd/mm/yyyy): / /
☐ 100 Normal; no complaints; no evidence of disease
☐ 90 Able to carry on normal activity; minor signs or symptoms
☐ 80 Normal activity with effort; some signs of symptoms of disease
☐ 70 Cares for self; unable to carry on normal activity or to do active work
☐ 60 Requires occasional assistance but is able to care for most of needs
☐ 50 Requires considerable assistance and frequent medical care
☐ 40 In bed more than 50% of time
☐ 30 Almost completely bedfast
☐ 20 Totally bedfast and requiring extensive nursing care by professionals and/or family
☐ 10 Comatose or barely rousable

Key symptom issues
☐ Pain ☐ Tiredness ☐ Nausea ☐ Depression ☐ Anxiety ☐ Shortness of breath
☐ Drowsiness ☐ Appetite ☐ Wellbeing ☐ Constipation ☐ Diarrhoea ☐ Other: _____

Produced by the Victorian Department of Health, 2012

This information collected by: PCSI Page 1 of 3
Name: Position/Agency:
Sign: Date: dd/mm/yyyy / / Contact number:

Palliative care supplementary information

If the consumer identifies as Aboriginal, ensure that the Aboriginal hospital liaison officer (AHLO) is informed. The AHLO will make arrangements to provide support to the Aboriginal consumer's family members, if required.

Reason for **admission** relates to inpatient episode/ admission.

Any specialist involved in the care of this person.

Approximate date is adequate (for example, year only).

The **key symptom issues** are consistent with the listing in the validated Edmonton Symptom Assessment Scale at: <www.hospicecare.com/resources/pain-research.htm>.

The purpose of this tool is to develop a statewide approach to referral to and from palliative care services.

This supplementary referral template contains essential palliative care information not contained elsewhere in the SCTT.

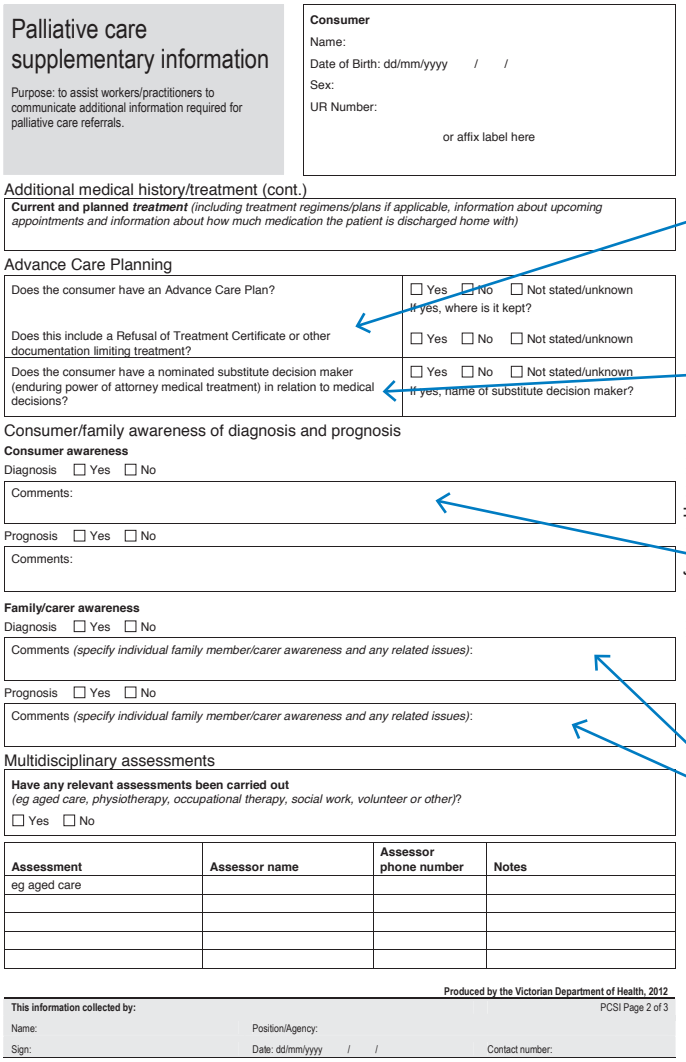
The information in the supplement should assist the service receiving the referral to determine appropriateness of the referral and how to triage the referral.

Completion of this tool is appropriate for any service (community, acute, primary care, palliative care) referring to a palliative care service.

Detailed information regarding the consumer's medical history should be recorded on the *Summary and referral information* template.

Palliative care supplementary information

Page 2



Palliative care supplementary information

Purpose: to assist workers/practitioners to communicate additional information required for palliative care referrals.

Consumer
Name:
Date of Birth: dd/mm/yyyy / /
Sex:
UR Number:
or affix label here

Additional medical history/treatment (cont.)

Current and planned *treatment* *(including treatment regimens/plans if applicable, information about upcoming appointments and information about how much medication the patient is discharged home with)*

Advance Care Planning

Does the consumer have an Advance Care Plan?	☐ Yes ☐ No ☐ Not stated/unknown If yes, where is it kept?
Does this include a Refusal of Treatment Certificate or other documentation limiting treatment?	☐ Yes ☐ No ☐ Not stated/unknown
Does the consumer have a nominated substitute decision maker (enduring power of attorney medical treatment) in relation to medical decisions?	☐ Yes ☐ No ☐ Not stated/unknown If yes, name of substitute decision maker?

Consumer/family awareness of diagnosis and prognosis

Consumer awareness

Diagnosis ☐ Yes ☐ No

Comments:

Prognosis ☐ Yes ☐ No

Comments:

Family/carer awareness

Diagnosis ☐ Yes ☐ No

Comments *(specify individual family member/carer awareness and any related issues)*:

Prognosis ☐ Yes ☐ No

Comments *(specify individual family member/carer awareness and any related issues)*:

Multidisciplinary assessments

Have any relevant assessments been carried out
(eg aged care, physiotherapy, occupational therapy, social work, volunteer or other)?
☐ Yes ☐ No

Assessment	Assessor name	Assessor phone number	Notes
eg aged care			

Produced by the Victorian Department of Health, 2012

This information collected by: PCSI Page 2 of 3

Name: Position/Agency:

Sign: Date: dd/mm/yyyy / / Contact number:

A *Refusal of treatment* certificate is the same as a *Not for treatment* order.

Medical power of attorney includes enduring medical power of attorney.

Consumer/family awareness is critical for appropriate communication in triaging referrals, planning care and assessing psychosocial needs.

Completion of the comments section related to family and carer awareness and any related issues is important for planning care and assessing psychosocial needs.

This tool does not replace the need for a follow-up telephone call after either making or receiving the referral.

At the time of publication, the Advance Care Planning (ACP) Implementation Strategy has not been released. See <health.vic.gov.au/acp> for ACP updated resources and links.

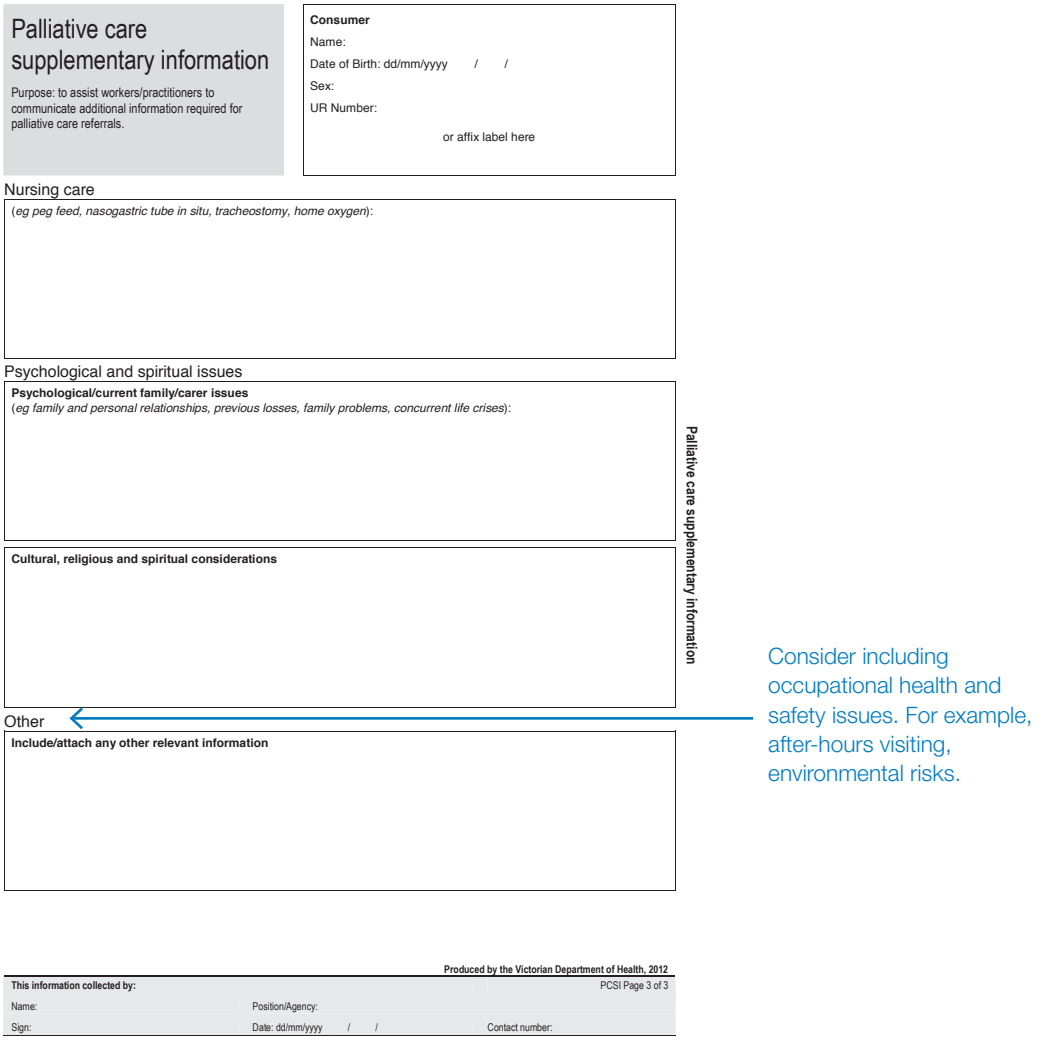
ACP is the process of planning for a person's future health and personal care. It helps ensure that an individual's choices are respected for future medical treatment. Their beliefs, values and preferences are made known in order to guide future care should the person be unable to make decisions or communicate. There are two main aspects to ACP:

- appointing a **substitute decision maker** In Victoria this is best done by appointing an enduring power of attorney (medical treatment)
  and/or
- discussing and documenting a person's wishes for care. Documentation of values, beliefs and preferences can provide clarity to the treating medical team.

ACP can be formal or informal, written or verbal, undertaken by a specialised health professional or by the person independently in their own environment. When a person has an ACP it is preferable that the health service holds a copy, because this improves the likelihood that the ACP will be seen and considered. It is also recommended that the person and their substitute decision maker (if applicable) also have a copy.

Palliative care supplementary information

Page 3



Palliative care supplementary information

Purpose: to assist workers/practitioners to communicate additional information required for palliative care referrals.

Consumer
Name:
Date of Birth: dd/mm/yyyy / /
Sex:
UR Number:
or affix label here

Nursing care

(*eg peg feed, nasogastric tube in situ, tracheostomy, home oxygen*):

Psychological and spiritual issues

Psychological/current family/carer issues
(*eg family and personal relationships, previous losses, family problems, concurrent life crises*):

Cultural, religious and spiritual considerations

Palliative care supplementary information

Other

Include/attach any other relevant information

Consider including occupational health and safety issues. For example, after-hours visiting, environmental risks.

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This information collected by: PCSI Page 3 of 3

Name: Position/Agency:

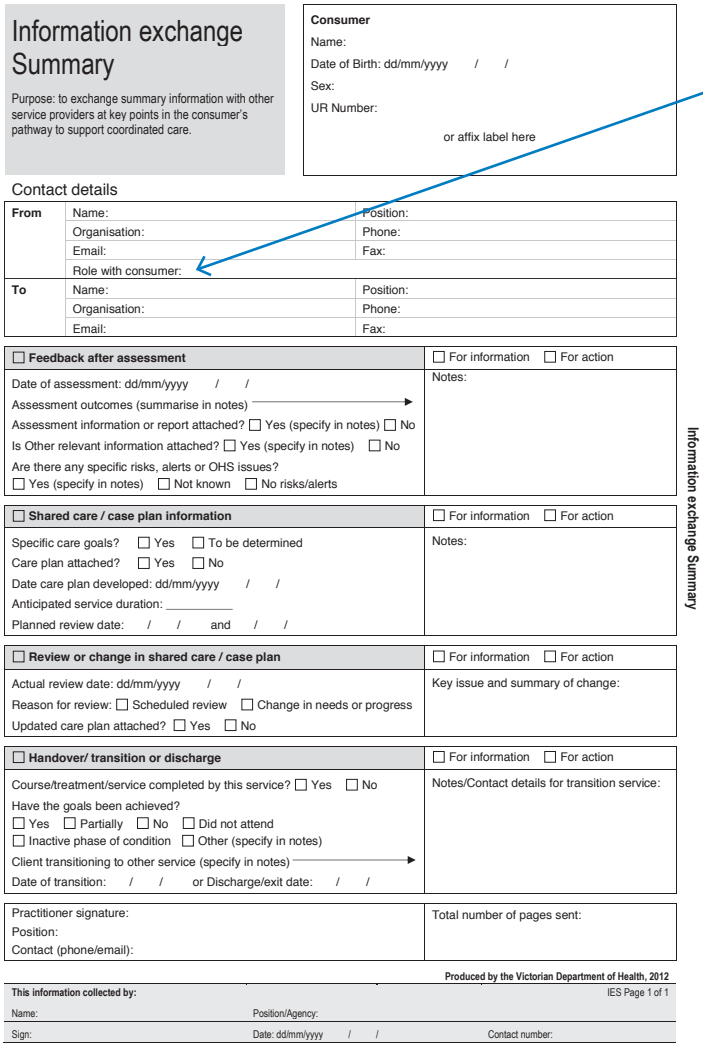
Sign: Date: dd/mm/yyyy / / Contact number:

Where complex family and social network situations exist, consider completing the *Care relationship family and social network, Accommodation and safety arrangements* and/or the *Social and emotional wellbeing* template.

For Aboriginal consumers, it is important to understand and acknowledge that the kith, kinship and community relationships are an important aspect of Aboriginal culture.

Information exchange

Information exchange summary



Information exchange Summary

Purpose: to exchange summary information with other service providers at key points in the consumer's pathway to support coordinated care.

Consumer
Name:
Date of Birth: dd/mm/yyyy / /
Sex:
UR Number:
or affix label here

This may be an intake worker, assessment officer, occupational therapist, key worker, case manager, care/ case coordinator etc.

Contact details

From	Name:	Position:
	Organisation:	Phone:
	Email:	Fax:
	Role with consumer:	
To	Name:	Position:
	Organisation:	Phone:
	Email:	Fax:

☐ **Feedback after assessment** — ☐ For information ☐ For action

Date of assessment: dd/mm/yyyy / /
Assessment outcomes (summarise in notes) →
Assessment information or report attached? ☐ Yes (specify in notes) ☐ No
Is Other relevant information attached? ☐ Yes (specify in notes) ☐ No
Are there any specific risks, alerts or OHS issues?
☐ Yes (specify in notes) ☐ Not known ☐ No risks/alerts

Notes:

☐ **Shared care / case plan information** — ☐ For information ☐ For action

Specific care goals? ☐ Yes ☐ To be determined
Care plan attached? ☐ Yes ☐ No
Date care plan developed: dd/mm/yyyy / /
Anticipated service duration: _____
Planned review date: / / and / /

Notes:

☐ **Review or change in shared care / case plan** — ☐ For information ☐ For action

Actual review date: dd/mm/yyyy / /
Reason for review: ☐ Scheduled review ☐ Change in needs or progress
Updated care plan attached? ☐ Yes ☐ No

Key issue and summary of change:

☐ **Handover/ transition or discharge** — ☐ For information ☐ For action

Course/treatment/service completed by this service? ☐ Yes ☐ No
Have the goals been achieved?
☐ Yes ☐ Partially ☐ No ☐ Did not attend
☐ Inactive phase of condition ☐ Other (specify in notes)
Client transitioning to other service (specify in notes) →
Date of transition: / / or Discharge/exit date: / /

Notes/Contact details for transition service:

Practitioner signature:
Position:
Contact (phone/email):

Total number of pages sent:

Produced by the Victorian Department of Health, 2012

This information collected by: IES Page 1 of 1

Name: Position/Agency:
Sign: Date: dd/mm/yyyy / / Contact number:

Information exchange Summary

The purpose of this supplementary template is to exchange summary information with other service providers at key points in the consumer pathway to support coordinated care.

The template reflects a stepped process to enable service providers to use it at each new stage of the care pathway. Each section of the template is completed at a different point in time as the consumer progresses through the care pathway from assessment, to care/case planning, to care/case plan review and exit.

The person collecting and sending the feedback has a duty of care to obtain the consumer's consent to share this information. For more information on consent to share information, including consent requirements for people who do not have the capacity to give consent, refer to page 17.

Shared support plan

Shared support plan

Page 1

Shared support plan

Purpose: for a consumer who requires multiple services, to support a coordinated approach. It shows who is involved in the consumer's care, the main issues, agreed goals developed together, planned actions and who is responsible for each action.

Consumer

Name:

Date of Birth: dd/mm/yyyy / /

Sex:

UR Number:

or affix label here

Consent to share information

Before developing this plan, ensure consent to share information has been given using the *SCTT: Consent to Share Information.*

I (or support person) understand and agree to this plan: ☐ Yes ☐ No

I (or support person) have a copy of the plan: ☐ Yes ☐ No

Reason for this plan:

Who is involved in the shared support plan?

Name	Role or area of support *(for example person receiving support, care coordinator, carer, GP)*	Contact details	Participant in planning process *(Yes/No)*	Has a copy of plan *(Yes/No)*
	Main Contact *(for example Care Coordinator)*		☐ Yes ☐ No	☐ Yes ☐ No
			☐ Yes ☐ No	☐ Yes ☐ No
			☐ Yes ☐ No	☐ Yes ☐ No
			☐ Yes ☐ No	☐ Yes ☐ No
			☐ Yes ☐ No	☐ Yes ☐ No
			☐ Yes ☐ No	☐ Yes ☐ No
			☐ Yes ☐ No	☐ Yes ☐ No
			☐ Yes ☐ No	☐ Yes ☐ No

Shared support plan

What other plans are in place?

Produced by the Victorian Department of Health, 2013

This information collected by:

Name: Position/Agency:

Sign: Date: dd/mm/yyyy / / Contact number:

It is important that the consumer understands the purpose and process of the development of a shared support plan and gives consent to share this information.

If the consumer does not have the capacity to participate in the development of the plan (for example, they are unable to understand or communicate sufficiently), then they (or a person engaged to represent them and help develop the plan) should be provided with the support they require to participate.

Record the main reason for developing the plan from the consumer's perspective. This can be helpful for the consumer when discussing the plan with others (family or service providers).

List all known care participants, their role or the relevant life domain (for example, carer, neighbour, counsellor, housing worker, GP) and contact details, if available.

Consumers, family members and/or carers, where relevant, should be empowered to participate in the development, implementation, monitoring and review of the shared support plan.

A person who will be the main contact for the consumer should be listed. This person may change with the nomination of a care/case coordinator.

This can include: assessments, existing treatment plans, care/case plans, service-specific plans, self-management plans, cultural support plans, safety/emergency plans, a shared risk management plan or other information that supports the shared support plan. These may be attached, if appropriate.

This tool is developed for consumers with multiple or complex needs, such as those with a chronic condition, high or ongoing support needs.

Check if the consumer has other care plans, such as a GP management plan or team care arrangement, which need to be included as documentation and may inform specific consumer goals.

For further information on cultural support plans for Aboriginal children in care, refer to page 67.

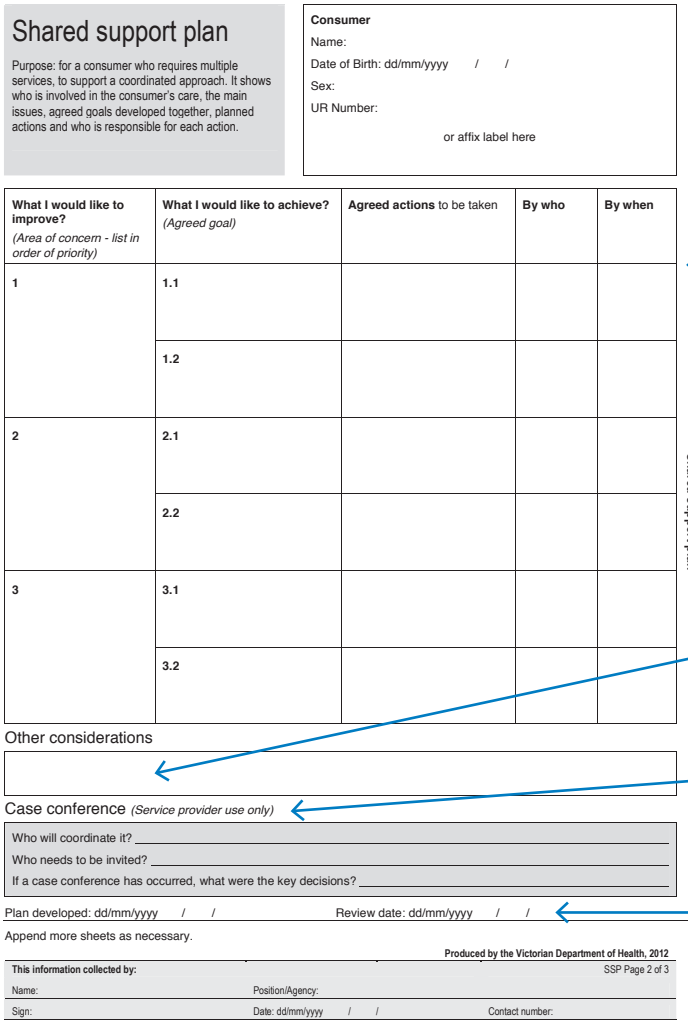
The role of the care/case coordinator is to:

- act as the key contact for the consumer and the service providers involved in the shared support plan throughout the life of the plan
- ensure that the consumer understands and consents to the planning process and the sharing of information between providers
- ensure that the consumer's goals are reflected in the plan and that they consent to the *Shared support plan*
- document and provide copies of the plan to participants, as agreed by the consumer
- ensure the plan is monitored and reviewed.

Refer to the *Victorian service coordination practice manual* for further information about the role of a care/case coordinator.

Shared support plan

Page 2



Shared support plan

Purpose: for a consumer who requires multiple services, to support a coordinated approach. It shows who is involved in the consumer's care, the main issues, agreed goals developed together, planned actions and who is responsible for each action.

Consumer
Name:
Date of Birth: dd/mm/yyyy / /
Sex:
UR Number:
or affix label here

What I would like to improve? *(Area of concern - list in order of priority)*	**What I would like to achieve?** *(Agreed goal)*	**Agreed actions** to be taken	**By who**	**By when**
1	**1.1**			
	1.2			
2	**2.1**			
	2.2			
3	**3.1**			
	3.2			

Shared support plan

Other considerations

Case conference *(Service provider use only)*

Who will coordinate it? _____
Who needs to be invited? _____
If a case conference has occurred, what were the key decisions? _____

Plan developed: dd/mm/yyyy / / Review date: dd/mm/yyyy / /

Append more sheets as necessary.

Produced by the Victorian Department of Health, 2012

This information collected by: SSP Page 2 of 3

Name: Position/Agency:

Sign: Date: dd/mm/yyyy / / Contact number:

List in priority order the main issues or problems, identified with the consumer, that need to be addressed through a coordinated approach.

For each issue/problem, identify with the consumer a practical and measurable goal.

List planned actions to achieve the goal. There may be one or more actions for each goal. Responsibility for each planned action may be the consumer or service provider.

The target date for each action will be an estimated achievable timeframe, as discussed with the consumer.

Information that is not directly related to goals, but may have an impact.

For more information to plan a case conference see pages 51–52.

Record the date the plan was developed and the date proposed for reviewing the overall plan.

This template documents the issues, goals and actions of the *Shared support plan,* as identified and agreed with the consumer.

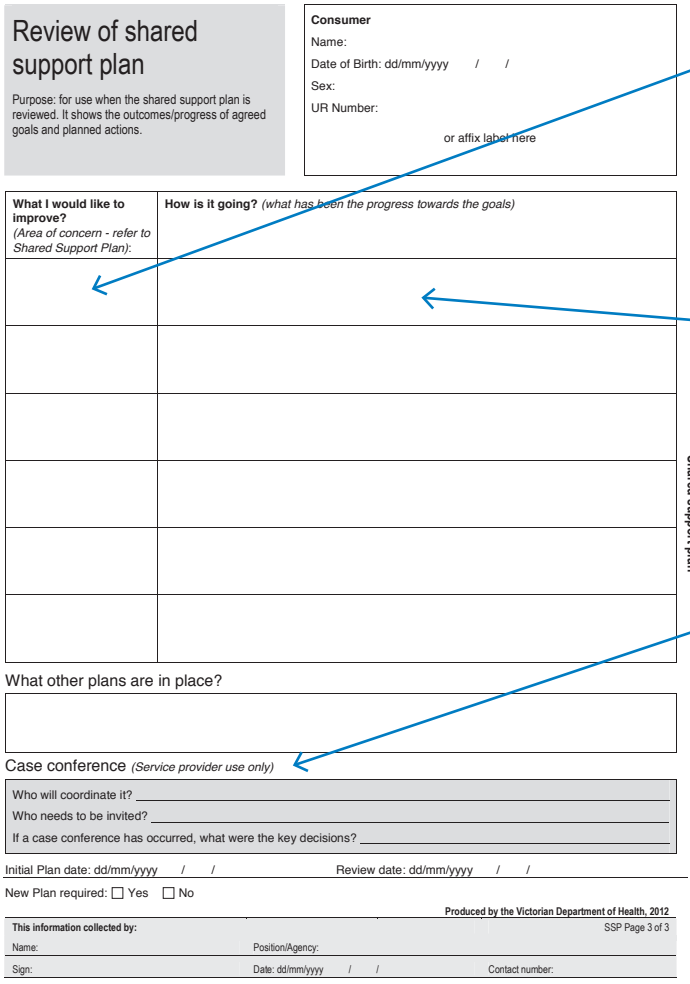
The goals need to be consumer centred and relate to practical actions that are relevant to the identified issues of the consumer.

Goals and actions must take into account the psychosocial environment and abilities of the consumer.

A self-management approach is to be promoted.

Shared support plan

Page 3



Review of shared support plan

Purpose: for use when the shared support plan is reviewed. It shows the outcomes/progress of agreed goals and planned actions.

Consumer
Name:
Date of Birth: dd/mm/yyyy / /
Sex:
UR Number:
or affix label here

What I would like to improve? *(Area of concern - refer to Shared Support Plan):*	**How is it going?** *(what has been the progress towards the goals)*

Shared support plan

What other plans are in place?

Case conference *(Service provider use only)*

Who will coordinate it? _____
Who needs to be invited? _____
If a case conference has occurred, what were the key decisions? _____

Initial Plan date: dd/mm/yyyy / / Review date: dd/mm/yyyy / /

New Plan required: ☐ Yes ☐ No

Produced by the Victorian Department of Health, 2012

This information collected by: SSP Page 3 of 3

Name: Position/Agency:

Sign: Date: dd/mm/yyyy / / Contact number:

Record reference number of issues and goals from *Shared support plan – page 2.*

Record the progress or outcome of actions related to each goal. Relevant information regarding progress of actions or interventions may include an explanation of why a goal was unable to be achieved or actions completed. For example, a change in the person's condition or environmental factors.

For more information to plan a case conference see pages 51–52.

This page is used to review information on the *Shared support plan* and to record progress, such as the actions completed or goals achieved.

The information may be gathered over time or at a review meeting or case conference, and is coordinated by the care/case coordinator.

Case conference checklist

Before beginning a case conference	
Check the consumer's eligibility and previous case conferencing information, if applicable.	☐
Obtain the consumer's (or authorised representative's) consent to discuss medical and social issues and care preferences with other providers.	☐
Develop a list of issues and identify health and wellbeing needs and goals.	☐
Identify and contact other participants/team members for participation in the case conference. Brief them on the issues/goals identified for discussion. Arrange the date, time, place and type of conference (face-to-face, telephone/video conference, combination and so on).	☐
Inform other participants if the consumer and the carer will be present during the case conference.	☐
Arrange an appointment following the case conference to discuss the outcomes with the consumer and carer.	☐
Undertaking the case conference	
Introduce all participants and establish the chair who will lead discussion.	☐
Outline purpose and goals of the conference; for example, the current profile of consumer (including areas of strength), assessments, issues, goals and so on.	☐
Invite any recent additional information or updates from the group and consumer.	☐
Identify actions and who will be responsible for them.	☐
Develop agreed processes for communication and indications for future case conferences.	☐
Arrange how and when the goals will be reviewed.	☐

Finalising the case conference	
Communicate the outcomes and recommendations arising from the case conference to the consumer and carer.	☐
Prepare the SCTT Shared support plan, including roles and responsibilities of participants.	☐
A copy of the SCTT Shared support plan should be: • filed in the consumer's record • given to the consumer and carer, including any other relevant documentation • sent to the participants in the consumer's care, including their GP.	☐
Schedule a date with the consumer and carer to review to assess the achievement of stated goals.	☐

Adapted from the *Checklist for Case Conference,* General Practice Association of Geelong at: <http://www.gpageelong.com.au/files/Practice_Support/Medicare_/Case_Conference_Checklist.pdf>.

This checklist is only a guide, and may be adapted to each service's requirements.

Most teams schedule a case conference in order to bring team members together at a set time to present and discuss a case. A case conference is a mechanism that supports a multidisciplinary approach to care. Case conferences are an ideal opportunity to have broader input into the decision-making process surrounding assessment and case management.

Not all care plans require a case conference. Agencies should develop criteria to determine when a case conference should occur. Guidelines can be developed to ensure a standardised and efficient process.

GP referral and emergency services

Referral from general practice

The *General practice referral* template (formerly Victorian Statewide Referral Form, or VSRF) provides standardised, quality referral information from general practice to other service providers.

The Department of Health and General Practice Victoria promote and support the *General practice referral* template as a replacement for the multitude of service-specific referral forms. Some local divisions of general practice/Medicare locals provide practical, on-the-ground support to general practice to integrate the *General practice referral* template into their practice. The *General practice referral* template has been incorporated in most clinical software applications used by general practices as a supplied template.

The aim of the *General practice referral* template is to enable GPs to send relevant, agreed demographic and clinical information about their patients to services, and for this to occur securely and seamlessly from their clinical information system.

To support effective reuse of information, data items in the *General practice referral* template that are duplicated in the SCTT use the same data standards.

The GP Referral template includes:

- referrer and referee information
- patient information
- clinical summary, including medications
- free text fields for additional information.

General practice referral

Page 1

General practice referral

Purpose: to provide a standardised quality referral from general practice to other service providers

Consumer
Name:
Date of Birth: dd/mm/yyyy / /
Sex:
UR Number:

or affix label here

Referral date: dd/mm/yyyy / /

Feedback requested: ☐ Yes ☐ No

Patient /consumer details

Name: Preferred name/s:

Date of Birth: / / Sex: Title:

Address:

Phone: Work: Mobile:

Email Alternative contact: Indigenous status:

Referral to:
Name:
Phone:
Fax:
Email:

Referring General Practitioner:
Name:
Phone:
Fax:
Email:
Provider number:

Service requested

Priority: ☐ urgent (list reason) ☐ non-urgent

Reason for patient referral

Other notes (for example current services)

Interpreter required: DVA number:
Preferred language: Insurance:
Pension card number: Medicare number:

General practice referral

Page 2

General practice referral

Purpose: to provide a standardised quality referral from general practice to other service providers

Consumer

Name:

Date of Birth: dd/mm/yyyy / /

Sex:

UR Number:

or affix label here

Clinical information

Warnings:

Allergies:

Current medication: **None known:** ☐

Drug name	Strength	Dose/frequency/special

Social history:

Medical history:

Investigation / Test results / Relevant plans (eg GPMP, Mental Health Treatment Plans):

Referral Acknowledgment: to be completed by agency/practitioner in receipt of referral

☐ To acknowledge a referral you have received, complete this section

From	Name:	Position:
	Organisation:	Phone:
	Email:	Fax:
To	Name:	Position:
	Organisation:	Phone:
	Email:	Fax:

Date referral received: dd/mm/yyyy / /

Status of referral: ☐ Accepted ☐ Wait listed ☐ Rejected (note reason and suggested alternatives)

Estimated date of assessment: dd/mm/yyyy / /

Contact person for further information: ☐ As above (From details) ☐ New contact (Provide in notes)

I am willing to be contacted regarding participating in a Team Care Arrangement. ☐

Notes:

Referral from Ambulance 000 referral service

The Ambulance triple zero (000) referral service can refer consumers that do not require a traditional ambulance response to appropriate health services. Locally based health services are better placed to maintain the continuum of care for consumers and initiate preventative care, such as falls management.

The objectives of the 000 referral service are to:

1. manage the demand for ambulance resources by identifying those 000 callers that do not require a traditional ambulance response and face-to-face emergency department consultation
2. better match consumer needs to locally based and appropriate health services
3. initiate ongoing case management of persons who are disconnected from their community, such as the elderly, who regularly contact 000.

Health services enter into an agreement with Ambulance Victoria to support this arrangement. This enables services linked to the 000 referral service to target specific groups, low-acuity conditions and patients with complex or chronic needs.

The *Ambulance Victoria referral* template enables the 000 referral service to communicate with health professionals across Victoria using a consistent recognisable format.

The AVRT includes:

- 000 referral service contact information and referral acceptance instructions
- patient details and contact information
- triage notes, including summary of events leading to referral
- triaged outcome and desired health management response
- consumer referral consent gained at the point of the 000 call
- referral acceptance and feedback contact details.

Telephone consultations or business agreements exist with all services receiving the *Ambulance Victoria referral* template.

Ambulance Victoria referral

Ambulance Victoria referral

Purpose: referral out to services that have a partnership agreement with Ambulance Victoria.

Consumer
Name:
Date of Birth: dd/mm/yyyy / /
Sex:
UR Number:

or affix label here

Referral date: dd/mm/yyyy / /

AV case number: _____

Referral to:
Name: _____
Phone: _____
Fax: _____
Email: _____

Referral from:
Name: AMBULANCE VICTORIA 000 Referral Service
Phone: _____
Fax: _____
Email: _____

Triage notes / summary of events leading to referral:

Reason for referral:

Ambulance Victoria referral

Patient details:
Name: _____
Address: _____
Phone: _____
Date of birth: dd/mm/yyyy / /
Gender: _____

Call details:
Time of call: _____
Nursing home patient: _____
Timeframe for referral advised: _____

The patient has consented to this referral. ☐

Please page 'referral service' on _____ on receipt of referral, or as per partnership agreement

Produced by the Victorian Department of Health, 2012

This information collected by: AVR pg 1 of 1

Name: Position/Agency:

Sign: Date: dd/mm/yyyy / / Contact number:

Aboriginal and Torres Strait Islander information resource

Aboriginal health and wellbeing in Victoria

Aboriginal and Torres Strait Islander peoples experience significantly more ill health than other Australians. They typically die at much younger ages and are more likely to experience disability and reduced quality of life because of ill health.

The following sections describe some of the social and health gaps between Aboriginal people and non-Aboriginal people.

Life expectancy

At the national level for 2005–07, the gap between Aboriginal and Torres Strait Islander and non-indigenous life expectancy was 11.5 years for males and 9.7 years for females.

Homelessness

Aboriginal people experienced homelessness at a rate almost four times that of non-indigenous Australians (1.9 per cent and 0.5 per cent respectively)

Mental health

Aboriginal males are almost six times more likely, and Aboriginal females are more than three times more likely to die from mental and behavioural disorders than other Australians.

Chronic disease

Aboriginal people experience higher rates of injury, and respiratory and circulatory disease – all often associated with disability.

Smoking

Aboriginal and Torres Strait Islander people remain twice as likely as non-indigenous people to be current daily smokers.

Disability

Aboriginal people overall are twice as likely as non-indigenous people to have a profound/severe core activity limitation.

Hospitalisation

The Aboriginal people rate of hospitalisation and presentation to emergency departments is higher than the non-Aboriginal rate for many specialities.

Infants

Aboriginal babies are twice as likely to be of low birth weight, and are more likely to die in their first year.

Close the Gap

The Close the Gap 2007 policy included in its recommendations for the Victorian Government to:

- improve access for Aboriginal and TSI people to culturally appropriate primary healthcare, to a level commensurate with need
- improve the responsiveness of mainstream health services and programs to the needs of Aboriginal peoples and Torres Strait Islander.

Victoria is rich in its diversity of cultures and languages, and the principles of service coordination practice are applicable to all people. However, achieving effective communication to provide health care to Aboriginal people remains complex. The following information supports service providers to effectively identify the needs of Aboriginal people and assist them to access the services they require in a culturally respectful way.

Communication

As with other Australians, the language and comprehension skills of Aboriginal consumers is strongly influenced by their level of formal education and life experiences.

The standard of education attained does not automatically determine how fluent an Aboriginal person is in understanding the spoken word. However, practitioners should ensure they do not use unnecessarily complex words or terminology when engaging with Aboriginal consumers. Some Aboriginal consumers will say 'yes' in response to a question to appease practitioners, even though they may not understand what is being asked of them.

Aboriginal consumers may use terminology that is local to their Aboriginal community, and this may be difficult for service providers to understand. If in doubt, service providers should arrange to have an Aboriginal Community Controlled Health organisation (ACCHO) or Aboriginal Community Controlled organisation (ACCO) staff member or a family member present during the assessment.

Asking the 'indigenous status' question

Core template: Consumer information

All Australian-born consumers should be asked at every admission/intake if they are of Aboriginal and/or Torres Strait Islander origin. The definition of an Aboriginal or Torres Strait Islander descent is a person who identifies themselves as an Aboriginal or Torres Strait Islander.

Aboriginal or Torres Strait Islander status should never be inferred from the person's appearance. It is the consumer's choice to identify themselves as Aboriginal. If the consumer is a child, the parent or guardian should always be asked if the child is of Aboriginal or Torres Strait Islander origin.

The following sentences can be used before asking a consumer any information related to their cultural background and identity:

> 'I now need to ask you some questions that we ask all consumers to help staff to tailor and provide appropriate care. These questions also help the government to plan and provide improved health care and services for everyone. Are you of Aboriginal and/or a Torres Strait Islander origin?'

Consumers who initially refuse to provide a response to the indigenous status question should be reassured that:

- the information will not affect their access to services
- the information is collected about all consumers
- the information will remain confidential (information will be de-identified)
- it is important information for ensuring that appropriate services are provided
- the information is needed to monitor and understand the health of different population groups in Australia.

Country of birth

Core template: Consumer information

In most instances, a person who says their 'country of birth' is not Australia is not of Aboriginal and/or Torres Strait Islander descent; however, this cannot be assumed.

Torres Strait Islanders

The Torres Strait Islands are part of Australia, and comprise over 100 islands which were annexed by Queensland in 1879. Torres Strait Islanders are the indigenous people of the Torres Strait Islands. They possess a heritage and cultural history distinct from Aboriginal traditions, are culturally and genetically linked to Melanesian peoples and those of Papua New Guinea. They are regarded as being distinct from other Aboriginal peoples of the rest of Australia and are generally referred to separately. There are 6,000 Torres Strait Islanders who live in the area of the Torres Strait, and 42,000 others who live outside of this area. Six per cent of indigenous Australians identified themselves fully as Torres Strait Islanders. A further four per cent of indigenous Australians identify themselves as having both Torres Strait Islander and Aboriginal heritage. Many indigenous organisations incorporate the phrase 'Aboriginal and Torres Strait Islander' to highlight the distinctiveness and importance of Torres Strait Islanders in Australia's indigenous population.

Preferred language

Core template: Consumer information

In Victoria there has been an uptake in the use of traditional language by some Aboriginal people; however, a significant majority of Aboriginal people living in Victoria only use English to communicate with other people.

Where a consumer has identified they are of Aboriginal and/or Torres Strait origin, practitioners should ask them if they have a preferred Aboriginal language. Aboriginal English is almost the same as English, the only difference is that this code indicates that the consumer's preferred language is based on Aboriginal cultural heritage.

The following language codes may be entered as a response to the Preferred Language question: 1201 English and 8998 Aboriginal English, so described.

Access to transport

Core template: Summary and referral information – page 2

Some Aboriginal consumers may not have ready access to private or public transport, so attending an appointment may be problematic. Where a referral is made by an ACCHO/ACCO, staff of the ACCHO/ACCO may be able to provide/arrange transport options for the person to attend an appointment.

If in doubt, ask the Aboriginal consumer if transport is going to be an issue for them if any follow-up appointments are required.

Rural Aboriginal consumers may have no option but to travel a long distance to receive approved medical specialist services. Where this occurs, practitioners should suggest that they submit an application to the Victorian Patient Transport Assistance Scheme (VPTAS), which subsidises the travel and commercial accommodation costs incurred by rural Victorians and an approved escort.

For more information about the VPTAS contact the Department of Human Services regional office or refer to the VPTAS guidelines at: <www.health.vic.gov.au/ruralhealth>.

Domestic

Optional template: Need for assistance with activities of daily living

Older Aboriginal people may be guardians or carers of grandchildren who live with them. It is likely that they will assume responsibility for doing most of the domestic tasks in their household.

Cognitive

Optional template: Need for assistance with activities of daily living

Aboriginal consumers have had life experiences that differ from those of other Australians as a result of policies implemented in the past by Australian governments. It is now widely acknowledged that a person's life experiences can strongly influence their responses to assessment questions, and that these should be taken into account by practitioners.

Aboriginal-specific cognitive assessment tools and process have been developed by several HACC Aboriginal services. With consumer consent, practitioners should involve HACC Aboriginal services in their cognitive assessments if the Aboriginal consumer has been referred to them by the ACCHO/ACCO.

With consent, ACCHO/ACCO staff and the Aboriginal consumer's family members can also provide information about the consumer's cognitive functioning capacity.

Chronic conditions

Optional template: Health and chronic conditions

Kidney disease and respiratory disease are serious and common health problems among Aboriginal people. Cardiovascular disease is the leading cause of disease burden amongst Aboriginal people.

Diabetes is nearly four times more prevalent among Aboriginal people than other Australians, but only half know they have the condition. Death from diabetes is up to 15 times more common for Aboriginal people.

Cancer rates in the 35–64 age group are twice as high for Aboriginal people. Cervical cancer is more common among Aboriginal women than other Australians.

High blood pressure is one and a half times more common in Aboriginal people.

The term 'chronic condition' may not be clear or readily understood when seeking this type of information from an Aboriginal consumer. Where appropriate, practitioners should provide an example of chronic conditions and the symptoms that may present in a person.

As with other consumers, it is important to stress to Aboriginal consumers that they can take action to manage or address the symptoms and causes of a chronic condition.

It is also important to advise Aboriginal consumers that there is assistance available under the Practice Incentive Program (PIP) to meet costs associated with purchasing medicines under the Pharmaceutical Benefits Scheme (PBS) and gaining access to follow-up healthcare specialists and allied health professionals.

Social and emotional wellbeing

Optional template: Social and emotional wellbeing

Many Aboriginal Australians have significant mental health issues that are linked to experiences of grief, loss and trauma. Aboriginal people conceptualise mental health as part of social, spiritual and emotional wellbeing. Practitioners should, therefore, be sensitive to the cultural meanings and needs of Aboriginal people.

Aboriginal Australians prefer the term 'social and emotional wellbeing' (SEWB) to 'mental health' because it is perceived as reflecting a more positive approach to health. The concept of social and emotional wellbeing has helped cast a light onto considerations of the mental health of indigenous people and encouraged observers – including indigenous people themselves – to consider mental health holistically by acknowledging and examining the broader socio-historical and personal choices that influence it.

Mental and behavioural disorders are the second-most common cause of disease burden amongst Aboriginal people in Victoria. Information available from diagnostic classifications indicates that some variation exists in diagnoses between Aboriginal and non-indigenous groups, where stress-related disorders and substance abuse disorders are slightly higher for the Aboriginal population.

A causal link may exist between alcohol and substance use and the incidence of mental and physical health issues for the general population, with a slightly higher incidence occurring with Aboriginal people. The incidences of family violence and mental health issues can also have a devastating impact on Aboriginal family structures because of the close-knit family and extended family relationships.

Spiritual, social and emotional wellbeing workers are employed by several ACCHO/ACCOs in Victoria and service providers should contact their local ACCHO/ACCO to confirm if they are on staff.

The Australian Indigenous Psychologists Association (AIPA) is the national peak body representing Aboriginal and Torres Strait Islander psychologists in Australia. For information about AIPA visit: <www.indigenouspsychology.com.au>.

For information about Aboriginal social and emotional wellbeing refer to the *Victorian Mental Health Reform Strategy 2009–19* at: <www.health.vic.gov.au/mentalhealth/reformstrategy>.

Aboriginal carers

Optional template: Care relationship, family and social network

In Aboriginal communities several cultural and historical dynamics have had a profound impact on how care is provided by Aboriginal carers, the kinds of support carers seek and how service providers respond to them.

The role of a carer in Aboriginal communities does not equate with the European notion of an individual who assumes the role of a primary care giver to a relative or friend who is unable to fully care for themselves. Aboriginal carers are usually immediate or extended family members. Most are women and they are of all ages. Most care for more than one person – often for three or four generations of family members with care needs. Indigenous families and carers care for their frail elderly and those with disability, mental illness and a range of chronic illnesses and conditions.

Where a large family network exists, the caring role will usually be shared between more than one person. For some Aboriginal children, a grandparent may take a leading role in their care. Carers can be a young person caring for a parent with a mental illness, an elder caring for a grandchild with a disability or aunties caring for a nephew with a substance abuse problem.

Very few indigenous people are identified as carers, even though many have significant care responsibilities. These responsibilities may limit the opportunities Aboriginal carers have to retain jobs, which in turn may have an impact on their level of income.

The stresses and pressures of caring for family members with an illness or disability are the same for all carers. However, for Aboriginal and Torres Strait Islander families, the historical experience of dispossession and racism has had a profound impact, resulting in higher levels of poor health, poverty and family trauma.

The health and wellbeing of Aboriginal carers has been identified as an area where more needs to be done, because many Aboriginal carers have major health issues themselves.

Practitioners should ensure that the health and wellbeing of Aboriginal carers is considered as part of decision-making processes, because the poor health of the carer will have a direct impact on the level and quality of care they can provide.

Where possible, practitioners should ask Aboriginal consumers and/or their carers if they are aware of the support and assistance they can receive (such as respite). They should also be asked if they are a member of a carer support group. Some example questions include:

> ‘I see that you have nominated a family member as a carer. Do you know that you can get respite care for you and your carer to take a break from each other?’
>
> ‘You said that your aunty/cousin is giving you carer support. Are there any other family members who are also providing you with carer support that we should know about?’
>
> ‘Do you know what supports are in place for Aboriginal carers? Would you like me to provide you with some information about this?’

The *Be with us Feel with us Act with us: Counselling and support for indigenous carers* 2005 report and the *Guidelines for delivery of culturally sensitive and flexible counselling for Indigenous carers* 2006 report both provide useful information about the situation of Aboriginal carers in Victoria.

For information about the help and assistance available to Aboriginal carers refer to Carers Victoria at: <www.carersvic.org.au> or to the Commonwealth Carer Respite Centre (1800 059 059).

Aboriginal family structures – immediate and extended family

Optional template: Care relationship, family and social network

Despite the devastating impact of European colonisation on traditional ways of life, the cultural values and practices of Aboriginal and Torres Strait Islander people continue. The importance of family is highly valued and is integral to culture. Aboriginal and Torres Strait Islander people continue to maintain a complex system of family connections. For instance, children may not just be the concern of the biological parents. The raising, care, education and discipline of children can be the responsibility of other family members.

Elders can bridge the past and the present and provide guidance for the future. They are a valuable resource in terms of skills knowledge and personal experiences. Thus, in indigenous societies, elders are treated with respect.

In non-Aboriginal society, an uncle or aunt is usually a mother's or father's sibling. In Aboriginal communities, it is accepted that a younger member of the community will refer to adults as 'uncle' or 'aunty' as a sign of respect. This does not mean people are related.

An Aboriginal person's connection with their family does not necessarily mean they are a blood relative. It means a 'connection' exists between people.

Non-Aboriginal people should not use these terms with Aboriginal people unless invited to do so. Do not call someone 'aunty', 'uncle' and so on, unless invited to do so.

Smoking

Optional template: ASSIST

Programs and activities that help people to quit smoking or try to prevent people from starting to smoke can either focus on individuals and their families, or can be aimed at entire communities and try to reach large numbers of people at the same time.

Practitioners should contact their local ACCHO/ACCO and Aboriginal Hospital Liaison Officer (AHLO) to confirm the support available in each community to assist Aboriginal consumers to quit smoking.

Alcohol

Optional template: ASSIST

While Aboriginal people are less likely to drink than non-indigenous Australians, those who do drink are more likely to drink excessively at high to very high levels and are more likely to binge drink (29 per cent compared with 17 per cent).

A number of ACCHO/ACCOs employ an alcohol and other drug worker. Practitioners should contact their local ACCHO/ACCO to find out about the work they are undertaking in the community and the Aboriginal-specific treatment services available to Aboriginal consumers.

Ngwala Willumbong (Pitjantjatjara for 'dry place') Co-operative Ltd has been a key service provider offering specialist alcohol and drug residential rehabilitation and outreach support services to Victorian Aboriginal communities since 1975.

For more information about alcohol treatment services for Aboriginal consumers refer to Ngwala Willumbong at: <www.ngwala.org>.

Shared support plan for Aboriginal consumers

Shared support plan template

Shared support plans for Aboriginal consumers may be something they are not familiar with, because they may be more used to service provider staff making decisions on their behalf.

To ensure that Aboriginal consumers are comfortable with the process undertaken to develop a *Shared support plan,* practitioners should ask the Aboriginal consumer if they would like someone to be present with them when their plan is being developed (such as an ACCHO/ACCO staff member or family member).

Aboriginal consumers referred by ACCHO/ACCOs are likely to already be receiving support from ACCHO/ACCO staff as part of their service interaction. Where this occurs, practitioners should ensure that staff are given the opportunity to identify any specific supports they can provide to the Aboriginal consumer.

Cultural support plan

Shared support plan template

Responding to the need to promote and sustain connectedness to culture, spirituality and community is an important aspect of all work with Aboriginal children and young people.

The *Children, Youth and Families Act 2005*, imposes a legislative requirement for Aboriginal children/young people in out-of-home care who are subject to a guardianship to secretary order or long-term guardianship to secretary order to have a cultural plan (known as a cultural support plan) developed.

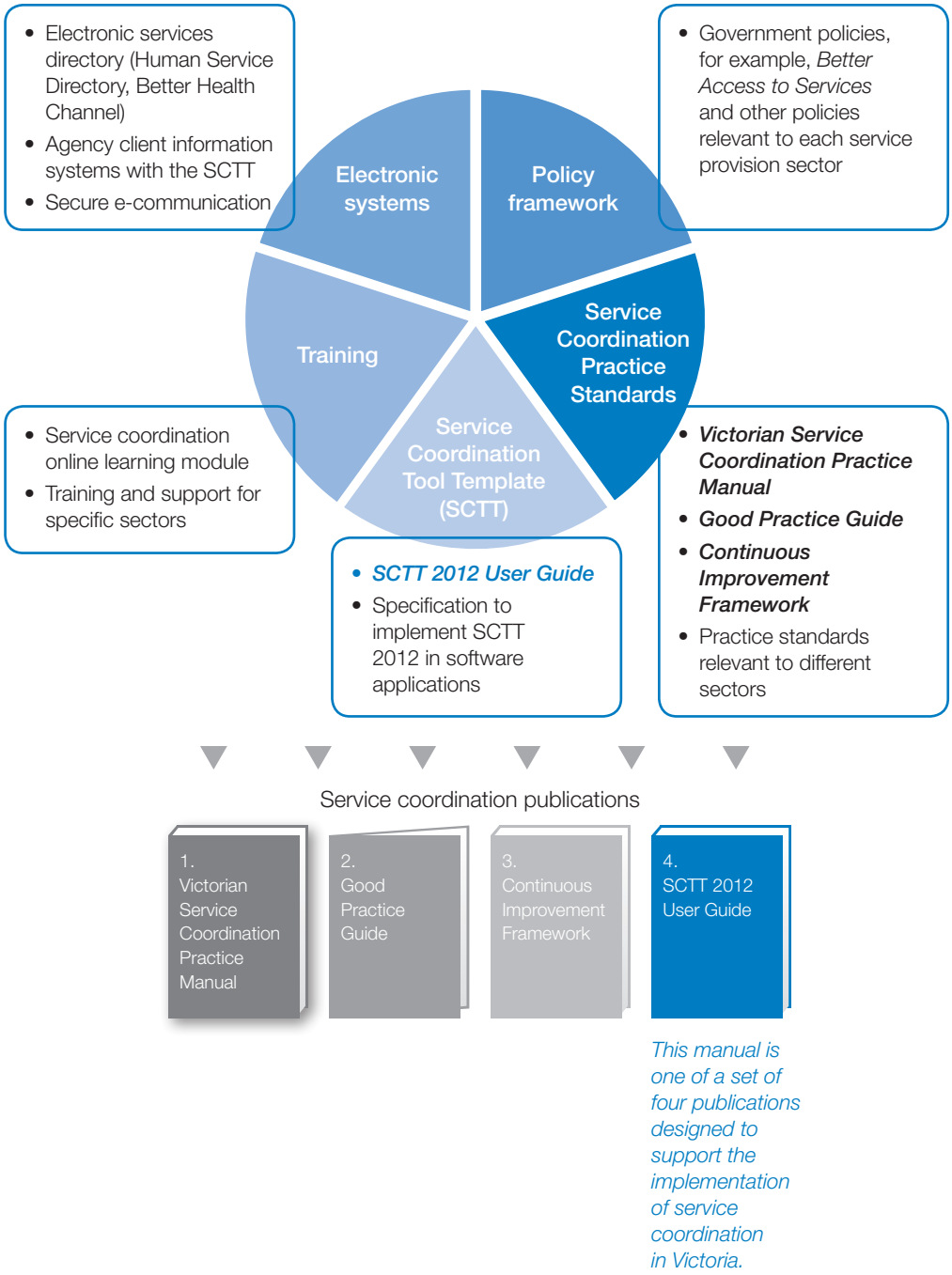
This plan sets out how this connectedness will be achieved and outlines specific strategies, tasks, responsibility for tasks and timelines. The development of the plan is usually referred to the local Aboriginal community controlled organisation; however, child protection is responsible for ensuring the plans are completed, implemented and monitored.

For more information about cultural support plans and Aboriginal children and families services visit: <http://www.cyf.vic.gov.au/indigenous-initiatives/home>.

References and resources

References and resources

Figure 1 References and where to find them



Policy

Better access to services – A policy and operational framework <http://www.health.vic.gov.au/pcps/publications/access.htm>.

Primary Care Partnerships overview <http://www.health.vic.gov.au/pcps/about/index.htm>.

Service coordination overview <http://www.health.vic.gov.au/pcps/coordination/index.htm>.

Working with general practice: Department of Human Services position statement <http://www.health.vic.gov.au/pch/gpp/working/index.htm>.

Service coordination practice

Victorian service coordination practice manual <http://www.health.vic.gov.au/pcps/downloads/sc_pracmanual2.pdf>.

Good practice guide – a resource of the Victorian service coordination practice manual <http://www.health.vic.gov.au/pcps/downloads/good_practice.pdf>.

Continuous improvement framework – a resource of the Victorian service coordination practice manual <http://www.health.vic.gov.au/pcps/downloads/continuous.pdf>.

Service access models: a way forward (a resource guide for Community Health) <http://www.health.vic.gov.au/pch/publications/chs_guide.htm>.

Service coordination tool template <http://www.health.vic.gov.au/pcps/sctt.htm>.

Working with general practice: Department of Human Services resource guide <http://www.health.vic.gov.au/pch/downloads/gp_resourceguide.pdf>.

Improving feedback to general practice <http://www.health.vic.gov.au/pch/gpp/working/index.htm>

Privacy

DH service coordination privacy resources <http://www.health.vic.gov.au/pcps/coordination/privacy.htm>.

Health Records Act 2001 <www.health.vic.gov.au/healthrecords>.

Health Privacy – It's my business <www.health.vic.gov.au/hsc/infosheets/disclosure.pdf>.

Information Privacy Act 2000 <www.privacy.vic.gov.au/privacy/web2.nsf/pages/home>.

Privacy Act 1988 <www.privacy.gov.au/act/index.html>.

Refusal of Treatment Certificate <http://www.publicadvocate.vic.gov.au/medical-consent/176>.

Client information management software application

The SCTT is available in most consumer information management software applications used by health and community service providers. Contact your software application vendor for more information about the availability of the SCTT in your consumer information management software application. Vendors can access SCTT2012 specifications from <http://www.health.vic.gov.au/pcps/coordination/info_management.htm>.

Electronic service directories

Human Services Directory <www.humanservicesdirectory.vic.gov.au>.

Better Health Channel <www.betterhealth.vic.gov.au>.

Workforce development

Service coordination online learning module
<http://www.health.vic.gov.au/pcps/workforce/index.htm>.

SCTT 2012 revision

Regular review of the SCTT has occurred since they were first implemented in 2003, with review cycles concluding in 2006 and 2009. This current review concluded in 2012, and is known as the SCTT 2012 revision project. The revision project commenced in June 2010. The revision project steering committee was formed to oversee the progress of the project, and included representatives from across Victorian State Government departments.

Project managers were appointed in November 2010. Thirteen project managers were appointed to facilitate thirteen working and two reference groups. These working groups were responsible for reviewing current templates and the development of new ones. There were 193 individual participants in the working and reference groups.

The following is a breakdown of the numbers representing different organisations: five state government departments, 19 hospital/health networks, 13 community health services, nine PCPs,12 peak bodies, 21 NGOs, 7 local governments, five GPs, four consultants, three consumers and three universities. The final templates were reviewed and endorsed by the service coordination tool templates 2012 revision project steering committee in August 2011.

The SCTT was piloted to ensure their utility, usability and practicality. Two workshops were held: one comprising 23 experienced SCTT users and the other comprising 12 novice/new users. In addition, a pilot was undertaken for both the consumer-administered and service provider-administered single page screener of health and social needs. The tool was piloted by 31 single and multisite agencies, including community health services, local governments, district health, district nursing, drug and alcohol, gambling, disability support and other services, with a total of 307 consumers participating.

The service coordination tool templates 2012 revision project has been the broadest to date, and has repositioned the SCTT from being health focused to also focusing on human services domains. In addition to delivering a set of templates that better meets the needs of clinicians and consumers the other objectives included better harmonisation of the SCTT data standards with national and National E-Health Transition Authority (NEHTA) standards and the development of technical resources that better support the atomised data implementation of the SCTT in the electronic systems used across the health and human services sector.

SCTT 2012 revision steering committee representatives

Carers Victoria

Department of Education and Early Childhood, Principle Medical Advisor

Department of Health, Aged Care

Department of Health, Aboriginal Health

Department of Health, Integrated Care

Department of Health, Mental Health and Drugs

Department of Health, Prevention and Population Health

Department of Health, Specialist Clinics

Department of Human Services, Disability Services

Department of Human Services, Housing and Community Building

Department of Human Services, Service Delivery and Performance

Department of Justice, Office of Gambling and Racing

Department of Planning and Community Development, Office of the community Sector

General Practice Victoria

Health Issues Centre

Lower Hume Primary Care Partnership

Municipal Association of Victoria

Victorian Council of Social Services

List of templates

Core referral templates	Description
The templates used to make a referral to another service. These templates contain the minimum information required for an effective referral and for the receiving service to act on the referral.	
Referral cover sheet and acknowledgement	Used when sending a referral and as an acknowledgement of receipt of a referral.
Consumer information	Contains: demographic information, contact details, general practitioner (GP) details, pension/ entitlements and insurance
Summary and referral information	Presenting issues, reason for referral, alerts, current services, list of referrals sent.
Consent to share information	Records consumer consent for the service provider to share information.[1] It is a requirement to obtain consent to share information, if the consumer has the capacity.

1 The associated one page brochure *Your information – It's private,* should be provided to the consumer.

Optional INI templates	Description
These templates record screening level information relevant to the consumer's circumstances and presenting needs. The templates can be used as part of the Initial Needs Identification process and to include in the referral. Service providers should use their professional judgement in deciding which templates and which items are relevant for each consumer.	
Single page screener for health and social needs	A screening tool used to identify a consumer's broad health and social needs.
Need for assistance with activities of daily living	Functional needs such as domestic, personal, mobility, transport, vision, communication, behaviour and cognition.
Accommodation and safety arrangements	Accommodation, family violence, personal emergency plans.
Health and chronic conditions	Overall health, chronic conditions, falls, nutritional risk, vision and advanced care planning.
Social and emotional wellbeing	Personal and social support, mental health and wellbeing.
Care relationship and family social network	Carers and care recipients; family network including children, young people, adults, parents, guardians, primary carer, grandparents, extended family members, friends and significant others; current pregnancy supports.
Alcohol, smoking and substance involvement screening (ASSIST)	Screening tool to identify issues relating to alcohol, smoking or substance use.

Supplementary referral templates	Description
Functional assessment summary	Records and shares information following an assessment of the consumer's functional abilities and need for assistance.
Palliative care information	Additional information required for palliative care referrals.
Information exchange summary	**Description**
Information exchange summary	Used to exchange summary information with other service providers at key points in the consumer's pathway to support coordinated care.
Shared support plan	**Description**
Shared support plan	Records a shared coordinated care/case plan for consumers with complex and/or multiple needs.
GP and emergency services	**Description**
GP referral	Used by general practitioners (GPs) when referring to other service providers.
Ambulance Victoria referral	Used by Ambulance Victoria when referring to services with Ambulance Victoria partnership agreements.