

CARE PLAN, CONSENT AND PRESCRIPTION

Teleconferences can be arranged by phoning Telstra Conferlink 1800 011 080 or Confertel 1800 505 075

Provider Name _____
Patient Name _____
Care Plan No _____

eProvider No _____
Patient ID No _____
Date ____/____/____

CHECKLIST

- | | | | |
|---|--|---|--|
| No other Active Plan | <input type="checkbox"/> YES <input type="checkbox"/> NO | Availability of providers ascertained | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Patient informed re Medicare charge | <input type="checkbox"/> YES <input type="checkbox"/> NO | Agreement of other providers | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Patient informed consent obtained | <input type="checkbox"/> YES <input type="checkbox"/> NO | Daily diary suggested to record Care Plan | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Any information withheld on request | <input type="checkbox"/> YES <input type="checkbox"/> NO | Plan distributed to providers | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Senior Health Questionnaire completed OR | <input type="checkbox"/> YES <input type="checkbox"/> NO | Plan distributed to patient | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Care Plan Assessments completed | <input type="checkbox"/> YES <input type="checkbox"/> NO | Plus Preventive Prescription (optional) | <input type="checkbox"/> YES <input type="checkbox"/> NO |

CARE PLAN PRESCRIPTION (review in 3 months if required)

(Code for Meeting in Person: F2F, Teleconference: TC) OR CONSULTED (Code: C)

#	PROVIDER	NAME	FREQUENCY	DURATION	SPECIFIED ACTIVITY INTENSITY & EXTENT	CONTACT CODE
1	Registered/Community nurse					
2	Meals on Wheels					
3	General Practitioner					
4	Medical Specialist					
5	Home Help					
6	Physiotherapist					
7	Podiatrist					
8	Pharmacist					
9	Social Worker					
10	Dietician					
11	Dentist/ dental therapist					
12	Optometrist					
13	Education provider					
14	Occupational therapist					
15	Psychologist					
16	Personal/ Respite Care Worker					
17	Weight Loss Program					
18	Speech pathologist					
19	Orthotist/Prosthetist					
20	Audiologist					
21	Aboriginal Health Care					
22	Day Care					
23	Probation officer					
24	Other :					

MEDICATIONS SUMMARY (inc. OTC & dressings) Self medicated Carer medicated

GOALS (written in words)

<input type="checkbox"/> Nutrition	<input type="checkbox"/> BMI	<input type="checkbox"/> Physical Function	<input type="checkbox"/> Mental Function	<input type="checkbox"/> PRA	<input type="checkbox"/> Overall Health Risk

Case Conference Date _____ **Care Plan Review Date** _____

Patient or Carer Signature/Agreement: _____