XXX REHABILITATION FOR CHRONIC CONDITIONS PROGRAM

XXX Local Health Service

Rehabilitation Plan	Date:	MRN:

Surname:

Other names:

DOB: ___ / ___ / ___ | Sex: F M X U

COB: | GP:

Specialist:

Medical clearance obtained? ☐ Not required

☐ Yes: medical practitioner:

Primary diagnosis:

Functional impairments:

- Physical:

☐ vision ☐ hearing ☐ speech

☐ mobility ☐ pain ☐ other

- Psychosocial:

- Cognitive:

Address details

Contact details Phone:

Email:

Emergency contact: Name:

Relationship: Phone:

Email:

Family or carer involvement: ☐ No

☐ Yes – provide details:

Name:

Relationship:

Contact:

Aboriginal or Torres Strait Islander

☐ Aboriginal ☐ Torres Strait Islander ☐ Neither

Aboriginal Liaison Officer

☐ Not required ☐ Required

CALD background ☐ No ☐ Yes

Language spoken at home:

Cultural background:

Special requirements:

Interpreter [Local telephone interpreter service number:]

☐ Not required

☐ Required

☐ Offered

☐ Provided

Transport assistance

☐ Not required ☐ Required, provide details:

Financial assistance ☐ Not required

☐ Bulk bill only ☐ Travel assistance

☐ Other:

Medical history:

Previous contact with this service? ☐ No ☐ Yes

Recent admissions:

Other issues:

Other services being provided

Medical services:

Social services:

Education provided? ☐ No ☐ Yes

Health literacy concerns identified? ☐ No ☐ Yes

The patient is aware of what is involved in the program: ☐ No ☐ Yes

Current medications include any complementary/alternative

Drug & dose	Prescribed	Comments

Rehabilitation goals Progress review key: √ = achieved (no further action) **M** = maintain (achieved + further action) **O** = ongoing (not achieved - further action) **X** = abandoned (no further action) **NK** = not known	Prog	End
1.		
2.		
3.		
4.		
5.		
6.		

Therapies/services required: circle as required and provide details below

Clinical psychology	Dietician	Medical
Neuropsychology	Nursing	Occupational therapy
Physiotherapy	Social work	Speech pathology

This plan identifies the patient's own goals for rehabilitation

☐ No ☐ Yes

Patient consent to share information

☐ written ☐ verbal ☐ implied