

XXX REHABILITATION FOR CHRONIC CONDITIONS PROGRAM

XXX Local Health Service

Rehabilitation Plan		Date:	MRN:
Surname:		<u>Address details</u>	
Other names:			
DOB: ___ / ___ / ___	Sex: F M X U	<u>Contact details</u> Phone:	
COB:	GP:	Email:	
Specialist:		<u>Emergency contact:</u> Name:	
Medical clearance obtained? <input type="checkbox"/> Not required <input type="checkbox"/> Yes: medical practitioner:		Relationship: Phone:	
		Email:	
Primary diagnosis:		<u>Family or carer involvement:</u> <input type="checkbox"/> No	
		<input type="checkbox"/> Yes – provide details:	
		Name:	
		Relationship:	
		Contact:	
		<u>Aboriginal or Torres Strait Islander</u>	
		<input type="checkbox"/> Aboriginal <input type="checkbox"/> Torres Strait Islander <input type="checkbox"/> Neither	
<u>Aboriginal Liaison Officer</u>		<input type="checkbox"/> Not required <input type="checkbox"/> Required	
		<u>CALD background</u> <input type="checkbox"/> No <input type="checkbox"/> Yes	
		Language spoken at home:	
		Cultural background:	
		Special requirements:	
Functional impairments:		<u>Interpreter</u> [Local telephone interpreter service number:]	
- Physical:		<input type="checkbox"/> Not required	
<input type="checkbox"/> vision <input type="checkbox"/> hearing <input type="checkbox"/> speech		<input type="checkbox"/> Required	
<input type="checkbox"/> mobility <input type="checkbox"/> pain <input type="checkbox"/> other		<input type="checkbox"/> Offered	
		<input type="checkbox"/> Provided	
- Psychosocial:		<u>Transport assistance</u>	
		<input type="checkbox"/> Not required <input type="checkbox"/> Required, provide details:	
- Cognitive:		<u>Financial assistance</u> <input type="checkbox"/> Not required	
		<input type="checkbox"/> Bulk bill only <input type="checkbox"/> Travel assistance	
		<input type="checkbox"/> Other:	

Medical history: Previous contact with this service? <input type="checkbox"/> No <input type="checkbox"/> Yes Recent admissions:	Education provided? <input type="checkbox"/> No <input type="checkbox"/> Yes												
	Health literacy concerns identified? <input type="checkbox"/> No <input type="checkbox"/> Yes												
	The patient is aware of what is involved in the program: <input type="checkbox"/> No <input type="checkbox"/> Yes												
	<u>Current medications</u> include any complementary/alternative												
		Drug & dose	Prescribed	Comments									
Other issues:													
<u>Other services being provided</u>													
Medical services:													
Social services:													
Rehabilitation goals	<u>Progress review key:</u> \checkmark = 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.													
<u>Therapies/services required:</u> circle as required and provide details below <table style="width: 100%; border: none;"> <tr> <td style="width: 33%;">Clinical psychology</td> <td style="width: 33%;">Dietician</td> <td style="width: 33%;">Medical</td> </tr> <tr> <td>Neuropsychology</td> <td>Nursing</td> <td>Occupational therapy</td> </tr> <tr> <td>Physiotherapy</td> <td>Social work</td> <td>Speech pathology</td> </tr> </table>			Clinical psychology	Dietician	Medical	Neuropsychology	Nursing	Occupational therapy	Physiotherapy	Social work	Speech pathology	This plan identifies the patient's own goals for rehabilitation <input type="checkbox"/> No <input type="checkbox"/> Yes Patient consent to share information <input type="checkbox"/> written <input type="checkbox"/> verbal <input type="checkbox"/> implied	
Clinical psychology	Dietician	Medical											
Neuropsychology	Nursing	Occupational therapy											
Physiotherapy	Social work	Speech pathology											