PART A

PART A contains information about Carer Details, My Role as the Carer, General Information About the Person I Support, Communication Care Needs and Physical Care Needs.

> Carer Details

Provide this information to the health professional in the emergency department or hospital ward who is admitting the person you support.

Carer information

Title	First name	Surname
Telephone	Mobile	Email
Relationship to the person I support is:		

I am the substitute decision maker YES ☐ NO ☐ If **NO**, details of substitute decision maker *(specify below)*

Title	First name	Surname
Telephone	Mobile	Email

I am the contact person YES ☐ NO ☐ If **NO**, details of other contact person *(specify below)*

Title	First name	Surname
Telephone	Mobile	Email

Is there another carer? YES ☐ NO ☐ If **YES**, details of other carer *(specify below)*

What is their relationship to the person you support?		
Title	First name	Surname
Telephone	Mobile	Email

> My Role as the Carer

Toileting	YES ☐	NO ☐
Assisting with eating	YES ☐	NO ☐
Dressing & grooming	YES ☐	NO ☐
Showering	YES ☐	NO ☐
Meal preparation	YES ☐	NO ☐
Laundry	YES ☐	NO ☐
Medication	YES ☐	NO ☐
Transport/driving	YES ☐	NO ☐
Cleaning	YES ☐	NO ☐
Shopping	YES ☐	NO ☐
Outings	YES ☐	NO ☐
Moving around	YES ☐	NO ☐
Finances	YES ☐	NO ☐
Others *(specify in next column)*	YES ☐	NO ☐

Others:

Rate how well supported you feel in your caring role.

Place an ✕ along the line below

SUPPORTED ——— NOT SUPPORTED

If you need more support at home, what support would help?

Expectation of involvement in health care for the person I support *(Tick the box that applies)*

I want to be involved in health care decisions *(e.g. doctor's visits and nursing care)* Yes ☐ No ☐

I want to participate in the planning decisions to prepare for transfer to another hospital, rehabilitation facility, residential care facility, or discharge home.

YES ☐ NO ☐

If **YES**, discuss your involvement with the doctor and nurse in charge of the area.

> General Information About the Person I Support

Provide this information to the health professional in the emergency department or hospital ward.

Name

Title	First name	Surname

What does the person like to be called?

Tell us about the person you support

e.g. normally very articulate and intelligent person who values their independence and privacy. Spent most of their working life as a chef. Enjoys talking about food and its preparation.

Language

Main language spoken at home	Is an interpreter needed? YES ☐ NO ☐ If **YES**, explain:

Regular doctor (general practitioner)

Name	Telephone

Name of medical practice

Address

Other health professionals and specialists

Name	Telephone

Type of health professional

Name of medical practice

Address

Other health professionals and specialists (continued)

Name	Telephone
Type of health professional	
Name of medical practice	
Address	

Living situation

Lives by self	YES ☐	NO ☐
Lives with main carer	YES ☐	NO ☐
Lives with other carer	YES ☐	NO ☐
Lives in an aged care facility	YES ☐	NO ☐
Other *(specify in next column)*	YES ☐	NO ☐

Other:

Community services used (in the last 6 months)

I/we currently receive assistance from:
(eg. Home Care Package (level), DVA services, Home Help, Meals on Wheels, Respite Care, overnight relief)

Type of service & how often received	Name of service & contact details

Visits to the emergency department and hospital admissions

Number of visits to the emergency department in the last 6 months			
Number of admissions to the hospital in the last 6 months			
Date of last hospital admission	____/____/____	TO	____/____/____
Name of hospital where last admitted			

History of confusion/dementia/delirium

Can get confused YES ☐ NO ☐

If **YES**, is this new or long standing?

What worsens their confusion?

What reduces their confusion?

The person I support was confused during their last hospital stay YES ☐ NO ☐

What do you think caused their confusion?

The person I support has been diagnosed with dementia YES ☐ NO ☐

Can you tell us what type?

Who made the diagnosis?

Approximate date of diagnosis

Advance Care Planning

Has an Enduring Power of Attorney been appointed? YES ☐ NO ☐
If **YES**, who has been appointed? *(specify below)*

Name	Contact details

Has someone been appointed to make medical decisions for the person you support? YES ☐ NO ☐
If **YES**, who has been appointed? *(specify below)*:

Name	Contact details

Does the person you support have an Advance Care Plan or similar directive document? YES ☐ NO ☐

Attach the Advance Care Plan to the back of this record or *My Health Record* if you have one.

If they do not have an Advance Care Plan, speak about it with the person you support and see your local doctor or other health professional at the hospital to initiate a plan.

> Communication Care Needs

Before this Hospital Admission

This information will assist health professionals to better communicate with the person you support.

Hearing

Has some deafness

☐ Right ear ☐ Left ear ☐ Both ears

Wears a hearing aid YES ☐ NO ☐

Is the hearing aid with them? YES ☐ NO ☐

Comments:

Vision

Has poor eyesight YES ☐ NO ☐

Wears glasses for reading YES ☐ NO ☐

Wears glasses for long distance vision YES ☐ NO ☐

Are their glasses with them? YES ☐ NO ☐

Comments:

Teeth

Wears denture/s or partial dentures YES ☐ NO ☐

☐ Top ☐ Bottom

Are their dentures with them? YES ☐ NO ☐

Comments:

Speaking

Has difficulty speaking YES ☐ NO ☐

Comments:

Memory

Has memory problems YES ☐ NO ☐

Comments:

The person I support needs assistance with

Remembering names, conversations and events	YES ☐	NO ☐
Remembering the time of the day, where they are and why they are here	YES ☐	NO ☐
Understanding what is being asked of them	YES ☐	NO ☐
Making decisions about their day to day care	YES ☐	NO ☐

Describe what type of assistance is needed for the items ticked.

What activities or behaviours may cause them to become upset or agitated?
(eg. showering, using the toilet, taking medications, asking them to do something)

If they become upset and/or agitated, what helps to settle them?

> Physical Care Needs

Before this Hospital Admission

This information on will assist health professionals understand the care needs of the person you support while they are in hospital.

Mobility

Walking, standing, moving around	Rising from a chair	Stairs
☐ Independent	☐ Independent	☐ Independent
☐ Manages with assistance	☐ Manages with assistance	☐ Manages with assistance
☐ Needs full support	☐ Needs full support	☐ Needs full support

Needs specific supervision or assistance with:

Uses a mobility aid YES ☐ NO ☐

Describe *(e.g. walking stick, walking frame, wheel chair)*:

Skin

Skin can easily be damaged, torn and/or bruised YES ☐ NO ☐

Does the person have any current skin tears or wounds?

Toileting

☐ Independent ☐ Manages with assistance ☐ Needs full support

Needs specific help with:

Describe their toileting routine:

Toileting (continued)

Wears a continence aid YES ☐ NO ☐

☐ Pad ☐ Catheter

Describe:

Toileting aid needed YES ☐ NO ☐

Describe *(e.g. raised toilet seat)*:

Do they experience constipation? YES ☐ NO ☐

What helps?

Eating a meal

☐ Independent ☐ Manages with assistance ☐ Needs full support

They need specific help with:

Uses an aid to help with eating YES ☐ NO ☐

Describe *(e.g. plate guard, cutlery with a moulded handle)*:

Dietary needs

Has recently been

☐ Gaining weight

☐ Losing weight. How much weight lost? ☐ Last known weight ☐

Has a special diet YES ☐ NO ☐

Dietary needs (continued)

Describe *(e.g. diet for diabetic control, semi-solid diet):*

Has a food allergy/allergies/intolerances YES ☐ NO ☐

Describe:

Likes the following foods:

Likes the following food but they should be minimised or avoided:

Describe why:

Dislikes the following foods:

Drinking

☐ Independent ☐ Manages with assistance ☐ Needs full support

Needs help with:

Uses an aid to help with drinking YES ☐ NO ☐

Describe (e.g. two handle cup):

Requires thickened fluids YES ☐ NO ☐

Describe the level of thickness:

Do they ever cough while drinking? YES ☐ NO ☐

Likes an alcoholic drink during the day YES ☐ NO ☐

Dressing/undressing

☐ Independent ☐ Manages with assistance ☐ Needs full support

Needs help with:

Bathing/showering/grooming

☐ Independent ☐ Manages with assistance ☐ Needs full support

Needs help with:

Sleep

☐ Independent ☐ Manages with assistance ☐ Needs full support

Needs help with:

Usual sleep and wake times:

Has daytime naps YES ☐ NO ☐

What time and how long?

Prefers to sleep through the night ☐ In a bed ☐ In a chair ☐ On a couch/daybed

How many pillows does the person sleep with? ☐

Has a routine that prepares them for sleep YES ☐ NO ☐

Describe *(e.g. 30 minutes before bedtime they have a warm drink of XXXX)*:

The person I support gets up at night and walks around the house YES ☐ NO ☐

What helps them sleep through the night?

What helps them to go back to sleep if they wake?

At night, the person experiences

☐ Pain ☐ Itching ☐ Cramp ☐ Restless legs ☐ Difficulty in breathing

Describe what assistance is needed for the items ticked: