

HOME-BASED CARE REFERRAL

Confidential

REFERRED TO: _____

Category

1	2	3
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Hospital File No: _____

PERSONAL INFORMATION

CONSENT FOR HB CARE

YES	NO
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Name: _____

ADDRESS: _____

TEL NO: _____ FOLDER NO: _____

DOB/ID: _____ RELIGION: _____

LANGUAGE: _____ GENDER:

M	F
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NEXT OF KIN: _____ RELATIONSHIP: _____

ADDRESS: _____

TEL NO: _____

MEDICAL INFORMATION

DIAGNOSIS: _____

ALLERGIES: _____ BP: _____ PULSE: _____

WEIGHT: _____ REPORT ATTACHED

YES	NO
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 DISCHARGE DATE: _____

DISCHARGE MEDICATION: _____

HOME-CARE REQUIREMENTS (tick box)

<input type="checkbox"/> POST NATAL SUPPORT	<input type="checkbox"/> FRAIL CARE	<input type="checkbox"/> HELP WITH EXERCISE
<input type="checkbox"/> INFANT/BREAST FEEDING SUPPORT	<input type="checkbox"/> DEFAULTER TRACING	<input type="checkbox"/> ARV ADHERENCE
<input type="checkbox"/> DRESSINGS / WOUND CARE	<input type="checkbox"/> TB DOTS	<input type="checkbox"/> MENTAL HEALTH ADHERENCE
<input type="checkbox"/> PRESSURE CARE	<input type="checkbox"/> JOIN SUPPORT GROUP	<input type="checkbox"/> MENTAL HEALTH (ACT)
<input type="checkbox"/> CATHETER CARE	<input type="checkbox"/> MEDS AT SUPPORT GROUP	<input type="checkbox"/> IMCI
<input type="checkbox"/> INCONTINENCE CARE	<input type="checkbox"/> PALLIATIVE CARE	<input type="checkbox"/> NTP

FOR TB DOT CLIENTS:

DATE TREATMENT COMMENCED: _____ REGIME: _____

1ST SPUTUM DATE: _____ 2ND SPUTUM DATE: _____ FINAL SPUTUM DATE: _____

STOCK SUPPLIED: _____

PLEASE SPECIFY ANY ADDITIONAL INFORMATION NECESSARY: _____

FOLLOW-UP DATE: _____

REFERRED FROM: _____

NAME: _____ SIGNATURE: _____

TEL: _____ FAX: _____ DATE: _____



CLIENT ASSESSMENT TOOL

ACTIVITIES OF DAILY LIVING			
1. MOBILITY			
MOVES WITHOUT HELP	1		
MOVES WITH HELP	2		
BEDRIDDEN, UNABLE TO MOVE WITHOUT HELP	3		
2. TOILETING			
ABLE TO HELP HIM/HERSELF	1		
NEEDS HELP	2		
UNABLE TO HELP HIM/HERSELF	3		
3. WASHING			
ABLE TO HELP HIM/HERSELF	1		
NEEDS HELP	2		
UNABLE TO HELP HIM/HERSELF	3		
4. MOUTH CARE			
ABLE TO HELP HIM/HERSELF	1		
NEEDS HELP	2		
UNABLE TO HELP HIM/HERSELF	3		
5. SHAVING			
ABLE TO HELP HIM/HERSELF	1		
NEEDS HELP	2		
UNABLE TO HELP HIM/HERSELF	3		
6. DRESSING			
ABLE TO HELP HIM/HERSELF	1		
NEEDS HELP	2		
UNABLE TO HELP HIM/HERSELF	3		
7. MEDICATION			
ABLE TO HELP HIM/HERSELF	1		
NEEDS HELP	2		
UNABLE TO HELP HIM/HERSELF	3		
8. DRESSING			
DRESSES AND UNDRESSES WITHOUT HELP	1		
DRESSES AND UNDRESSES WITH HELP / NEEDS REMINDER	2		
UNABLE TO DRESS / UNDRRESS	3		
9. MEDICATION			
TAKES MEDICATION WITHOUT HELP	1		
REQUIRES HELP WITH MEDICATION	2		
UNABLE TO TAKE OWN MEDICATION	3		
MENTAL STATUS			
10. ORIENTATION			
KNOWS TIME, PLACE AND PEOPLE	1		
NEEDS HELP	2		
UNABLE TO TELL DATE, TIME OR PLACE	3		
11. MEMORY			
MEMORY GOOD / NO HELP NEEDED	1		
NEEDS HELP	2		
UNABLE TO TELL DATE, TIME OR PLACE	3		
12. ABILITY TO UNDERSTAND INSTRUCTION / COMPREHENSION			
ABLE TO UNDERSTAND WHEN ASKED TO DO SOMETHING	1		
NEEDS HELP TO UNDERSTAND / COMPREHEND	2		
UNABLE TO UNDERSTAND	3		
13. COPING SKILLS			
ABLE TO COPE WITH THEIR EMOTIONS	1		
REQUIRES HELP COPING WITH EMOTIONS	2		
UNABLE TO COPE WITH EMOTIONS	3		
14. BEHAVIOUR			
NO DIFFICULT BEHAVIOUR	1		
SOMETIMES BEHAVIOURAL PROBLEMS	2		
CONSTANT DIFFICULT BEHAVIOUR	3		

SCORE	CATEGORY	CATEGORY DESCRIPTION	HOME-BASED PACKAGE	TOTAL
0 - 14	1	INDEPENDENT	SCREEN, TRAIN FAMILY, REFERRAL TO OTHER DISCIPLINES / SUPPORT GROUPS	
15 – 28	2	REQUIRE MINIMUM ASSISTANCE	MODERATE HBC NEEDED	
29 - 42	3	REQUIRE MAXIMUM ASSISTANCE	INTENSE HBC NEEDED	