Redesigned Mental Health Clinical Documentation: Notification of Availability

**Summary**  
Policy Directive PD2005_358 specifies the mandatory implementation of standardised mental health clinical documentation within public mental health services. The purpose of this Information Bulletin is to notify mental health staff of the availability of redesigned mental health clinical documentation. The modules have been redesigned in response to the comprehensive evaluation undertaken during 2006/07, with the redesign overseen and endorsed by the Mental Health Programs Council. The modules are available for order from Salmat from September 10, 2008.

**Document type**  
Information Bulletin

**Document number**  
IB2008_047

**Publication date**  
15 September 2008

**Author branch**  
Mental Health and Drug and Alcohol Office

**Branch contact**  
8877 5109

**Review date**  
15 September 2013

**Policy manual**  
Not applicable

**File number**  
N/A

**Previous reference**  
N/A

**Status**  
Obsolete

**Obsolete note**  
This Information Bulletin seeks to notify mental health services of the availability of redesigned Mental Health Clinical Documentation in 2008. Given the time lapse in the release of this information bulletin, it has been assessed as no longer required.

**Obsolete date**  
04 August 2017

**Functional group**  
Corporate Administration - Purchasing, Information and Data
Clinical/Patient Services - Mental Health

**Applies to**  
Area Health Services/Chief Executive Governed Statutory Health Corporation, Community Health Centres, Public Hospitals

**Distributed to**  
Public Health System, Community Health Centres, Divisions of General Practice, Government Medical Officers, Health Professional Associations and Related Organisations, Ministry of Health, Public Hospitals, Tertiary Education Institutes

**Audience**  
Area Mental Health Directors; mental health clinical staff; medical records staff; purchasing staff

Secretary, NSW Health  
This Policy Directive may be varied, withdrawn or replaced at any time. Compliance with this directive is mandatory for NSW Health and is a condition of subsidy for public health organisations.
REDESIGNED MENTAL HEALTH CLINICAL DOCUMENTATION: NOTIFICATION OF AVAILABILITY

The purpose of this Information Bulletin is to notify Area Mental Health Services of the availability of redesigned Mental Health Clinical Documentation which can be ordered from Salmat from September 10 2008 via existing Area authorisation processes. The current modules will become obsolete and will no longer be available for order from Salmat as of the same date.

Policy Directive PD2005_358 specifies the mandatory implementation of standardised mental health clinical documentation within public mental health services. During 2006/07 evaluation of the MH-OAT clinical documentation was conducted utilising a range of methods, with survey feedback received from nearly 700 mental health clinicians and managers and findings also available from nearly 4000 file audits.

In response, NSW Health has undertaken a comprehensive redesign of the MH-OAT clinical documentation. The redesign has been overseen by the NSW Mental Health Program Council, through a Steering Committee which included mental health consumers, professionals of all disciplines and peak bodies representing Psychiatrists and Psychiatry trainees. On April 18th 2008 the NSW Mental Health Program Council endorsed the revised suite of modules for implementation. The redesigned suite also reflects the adoption of NSW Health’s State Forms Management Committee’s approved template.

Areas are expected to utilise the redesigned modules as soon as possible to facilitate standardisation of documentation practices across the state.

A price list for the documentation is attached to facilitate initial purchase, along with PDFs of the documentation. It is important to note that Salmat’s inventory management approach focuses on maintaining an estimated 3 month usage level of the documentation, to enable responsiveness to any changes or new developments. To facilitate implementation of the documentation Guidelines on the Use of the Redesigned Mental Health Clinical Documentation will also be distributed.

Further information and clarification about the availability of the redesigned modules can be obtained from Ms Neda Dusevic, Project Manager MH-OAT on (02) 8877 5109.

Further guidance:-
- Standard Forms Stocked by cmSolutions (Government Printing Service) IB2005_017
- MH-OAT Clinical Assessment Protocols and Modules – NSW Standardised PD2005_358

David McGrath
Director Mental Health Drug and Alcohol Office
Pricing of Mental Health Clinical Documentation

The documentation will be packaged in bundles of 100 and will be ordered in lots of 100. The prices below are for each bundle of 100. The prices include warehousing costs. The prices do not include delivery.

The prices are based on estimated 3 month usage rates. If these usage rates change then the price will vary accordingly.

As of 1st September 2008 delivery costs will be charged at:

Metropolitan Delivery: $12.50 + GST (per 16kg parcel)

NSW Country Delivery: $19.00 + GST (per 16kg parcel)

<table>
<thead>
<tr>
<th>Mental Health Clinical Documentation</th>
<th>Cost per package of 100</th>
<th>Inclusive of GST</th>
</tr>
</thead>
<tbody>
<tr>
<td>Triage</td>
<td>$9.74</td>
<td>$10.71</td>
</tr>
<tr>
<td>Assessment</td>
<td>$19.68</td>
<td>$21.65</td>
</tr>
<tr>
<td>Care Plan</td>
<td>$11.16</td>
<td>$12.28</td>
</tr>
<tr>
<td>Review</td>
<td>$9.74</td>
<td>$10.71</td>
</tr>
<tr>
<td>Transfer/Discharge Summary</td>
<td>$6.65</td>
<td>$7.32</td>
</tr>
<tr>
<td>Physical Examination</td>
<td>$11.16</td>
<td>$12.28</td>
</tr>
<tr>
<td>Physical Appearance</td>
<td>$26.31</td>
<td>$28.94</td>
</tr>
<tr>
<td>Risk Assessment</td>
<td>$14.57</td>
<td>$16.03</td>
</tr>
<tr>
<td>Substance Use Assessment</td>
<td>$14.57</td>
<td>$16.03</td>
</tr>
<tr>
<td>Family Focused Assessment (COPMI)</td>
<td>$27.83</td>
<td>$30.61</td>
</tr>
<tr>
<td>Functional Assessment (Older People)</td>
<td>$15.31</td>
<td>$16.84</td>
</tr>
<tr>
<td>Screening for Domestic Violence</td>
<td>$13.16</td>
<td>$14.47</td>
</tr>
<tr>
<td>Cognitive Assessment (RUDAS)</td>
<td>$24.96</td>
<td>$27.45</td>
</tr>
<tr>
<td>Cognitive Assessment (3MS/MMS)</td>
<td>$24.96</td>
<td>$27.45</td>
</tr>
<tr>
<td>Consumer Wellness Plan</td>
<td>$27.83</td>
<td>$30.61</td>
</tr>
</tbody>
</table>
**Mental Health**

**TRIAGE**

**CONSUMER CONTACT NUMBERS:**

ALERTS/RISKS?  No  Yes  Summary (summarise after triage completed)

**TRIAGE DETAILS**

Date:  
Time:  
Location:  

Communication issues (e.g. language or cultural barriers, sensory impairment)

Information taken by:  Face to face  Phone  Other:

Purpose of contact (tick appropriate option):  Seeking assistance/referral  Information

Is client/primary carer aware of referral?  
Referred by:

Reason for referral (Include whether client is opposed to referral)

**HISTORY** (e.g. past diagnoses, interventions, information on family history)

**MEDICAL ISSUES** (e.g. significant illnesses, allergies, adverse drug reactions, delirium risk, pregnancy)

**CURRENT TREATMENTS** (e.g. medications, psychological interventions, complementary/alternative interventions, providers/services involved)

**DRUG AND ALCOHOL USE**

**CURRENT FUNCTIONING AND SUPPORTS** (e.g. concerns regarding living situation, parental or other carer responsibilities, note name, age, current whereabouts of dependent(s))

Staff Name:  
Signature:  
Designation:  
Date:  

Page 1 of 2
### Mandatory

| First Name: ___________________________ | Surname: ___________________________ | DOB: ___________________________ | MRN: ___________________________ |

#### Legal Status/Forensic Issues
(e.g. Mental Health Act involuntary patient orders, Guardianship)

#### Mental State Impressions
(consider information provided by client and other sources)

### Possible Risks

<table>
<thead>
<tr>
<th>Y=Yes, N=No, UK=Unknown</th>
<th>Suicide</th>
<th>Violence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Y</td>
<td></td>
<td></td>
</tr>
<tr>
<td>N</td>
<td></td>
<td></td>
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<tr>
<td>UK</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- Significant past history of risk
- Recent thoughts, plans, symptoms indicating risk
- Recent behaviour suggesting risk
- Concern from others about risk (assessment should include corroboration where possible)
- Current problems with alcohol or substance misuse
- Major mental illness or disorder
- At risk mental state (e.g. depressed, hopelessness, despair, guilt, marked agitation, disorganisation, intoxication)
- Person’s level of risk appears to be highly changeable
- Significant uncertainty in the assessment of the level of risk

### Overall Risk (current/immediate)

- High
- Med
- Low

#### Suicide

- Y
- N
- UK

#### Violence

- Y
- N
- UK

#### Other*

- Consider other risks e.g. self-harm, child safety, absconding, exploration, domestic violence, abuse, neglect, environment risks

### Summary
(overall clinical impression, including possible risks; please also document any ‘Alerts/Risks’ on Page 1)

### Action Plan

#### Urgency of response

- A Immediate
- B Within 2 hours
- C Within 12 hours
- D Within 48 hours
- E Within 2 weeks
- F Requires further triage contact/follow up
- G No further action required

- Department of Community Services notified
- Police notified
- Ambulance notified
- Referred to Inpatient Mental Health service
- Referred to Community Mental Health service
- Aboriginal Liaison Officer notified
- Other:

  **Details of Action Plan:**

  ...

### Contacts

<table>
<thead>
<tr>
<th>Communication undertaken with</th>
<th>Name</th>
<th>Contact details</th>
<th>Comments/issues</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
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<td>Yes</td>
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<tr>
<td>Yes</td>
<td></td>
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</tr>
</tbody>
</table>

| Staff Name: ___________________________ | Signature: ___________________________ | Designation: ___________________________ | Date: ___________________________ |

SMR025.000  Page 2 of 2
ASSESSMENT

CONSUMER CONTACT NUMBERS:

ALERTS/RISKS?  No  Yes  Summary (summarise after assessment complete, for more detail see Summary/formulation page 7)

ASSESSMENT DETAILS

Date:  Time:  Location:

Reason for referral (Include mental health legal status at presentation)

Sources of information (Indicate if corroborative history obtained, interpreter used, old notes accessed, details of people present at assessment)

Communication issues (e.g. language or cultural barriers, sensory impairment)

History of presenting problem (e.g. current symptoms, time course of current problems, any treatment already received for this problem/episode, relevant negatives, current risk)

Complete all details or affix patient label here
### Mental Health Site

#### ASSESSMENT

**PAST PSYCHIATRIC/MENTAL HEALTH HISTORY**
(e.g. past episodes of current or other mental health problems, past treatments and hospitalisations, engagement with care)

<table>
<thead>
<tr>
<th>Staff Name:</th>
<th>Signature:</th>
<th>Designation:</th>
<th>Date:</th>
</tr>
</thead>
</table>

**LEGAL ISSUES**
(document current legal orders e.g., Guardianship, Protective Order; document past, current, pending court cases, conviction for violent offences)

**DRUG AND ALCOHOL HISTORY**
(e.g. past and current substance use, amounts and frequency, features of dependence and abuse, prior treatments and their outcomes)

Indicate if **Substance Use Assessment** completed: No [ ] Yes [ ] N/A [ ]

**FAMILY MEDICAL/MENTAL HEALTH HISTORY**
(e.g. mental health, addiction or significant physical problems in parents or relatives; their treatments, experience of illness and care)

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*SMR025.010 Page 2 of 8*
**ASSESSMENT**

**MEDICAL HISTORY**
(e.g. medical conditions and treatments, relevant systems review, relevant investigations and results)

**Allergies/adverse drug reactions**
(includes non-medication allergies, give details, document any alerts on page 1)

**CURRENT TREATMENTS**

<table>
<thead>
<tr>
<th>Current Medications (use generic)</th>
<th>Dose/frequency/route</th>
<th>Comments (e.g. prescriber, side effects, adherence)</th>
</tr>
</thead>
</table>

**Additional information**
(e.g. medications recently ceased and reasons)

**Other treatments**

---

**Staff Name:**

**Signature:**

**Designation:**

**Date:**
ASSESSMENT

DEVELOPMENTAL AND PERSONAL HISTORY
(e.g. genogram; family, perinatal, childhood, and adolescent development; social, intellectual development, recreational, educational and employment history; premorbid personality; abuse and neglect)

<table>
<thead>
<tr>
<th>Male</th>
<th>Female</th>
<th>Pregnancy</th>
<th>Marriage Relationship</th>
<th>Separation</th>
<th>Divorce</th>
<th>Twins</th>
<th>Adoption</th>
<th>Significant Illness</th>
<th>Death</th>
<th>Non-marriage Relationship</th>
<th>Miscarriage abortion</th>
<th>Unknown gender</th>
<th>Focal group of individuals</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Staff Name:</th>
<th>Signature:</th>
<th>Designation:</th>
<th>Date:</th>
</tr>
</thead>
</table>
Site

**ASSESSMENT**

**CURRENT FUNCTIONING AND SUPPORTS**

(e.g. living situation, accommodation issues; family; relationships; other supports; social, educational, vocational functioning; ability to undertake responsibilities, daily tasks; financial issues, gambling; note strengths and weaknesses, any rehabilitation needs)

Indicate if **Functional Assessment (Older People)** completed

<table>
<thead>
<tr>
<th>No</th>
<th>Yes</th>
<th>N/A</th>
</tr>
</thead>
</table>

**PARENTAL STATUS AND/OR OTHER CARER RESPONSIBILITIES** (If pregnant, consider in Initial Management Plan as appropriate)

Does the person have responsibility for children aged 18 years or less?

<table>
<thead>
<tr>
<th>No</th>
<th>Yes</th>
</tr>
</thead>
</table>

Does the person have any contact with children through access visits or shared residence?

<table>
<thead>
<tr>
<th>No</th>
<th>Yes</th>
</tr>
</thead>
</table>

Does the person have other carer responsibilities? (e.g. aged or disabled adult)

<table>
<thead>
<tr>
<th>No</th>
<th>Yes</th>
</tr>
</thead>
</table>

**DETAILS OF CHILDREN AND/OR OTHER DEPENDENTS**

<table>
<thead>
<tr>
<th>Name (First name &amp; surname)</th>
<th>Relationship</th>
<th>Age/Date of birth</th>
<th>Current whereabouts</th>
</tr>
</thead>
<tbody>
<tr>
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</table>

Indicate if **Family Focussed Assessment (COPMI)** completed

<table>
<thead>
<tr>
<th>No</th>
<th>Yes</th>
</tr>
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</table>

Are there concerns about the safety of the child, young person or other dependent?

<table>
<thead>
<tr>
<th>No</th>
<th>Yes</th>
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</thead>
</table>

If risk identified, where is the management plan documented?

Staff Name:  
Signature:  
Designation:  
Date:  

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## Mental Health Site

### ASSESSMENT

**MENTAL STATE EXAMINATION**

- **Appearance** *(e.g. physical description, level of personal hygiene and grooming)*

- **Behaviour During Interview** *(e.g. rapport, engagement, psychomotor activity, interactions at assessment)*

- **Affect** *(observed emotional responses e.g. appropriate, restricted, flattened)*

- **Mood** *(reported feeling or emotion e.g. depressed, angry, euphoric or distressed)*

- **Speech** *(e.g. quantity, rate, volume, tone, unusual characteristics)*

- **Thought Form** *(e.g. logical, tangential, blocked, concrete)*

- **Thought Content** *(e.g. obsessions, delusions, suicidal or homicidal ideation, view of future; for children consider play and fantasy)*

- **Perception** *(e.g. auditory, visual or somatic hallucinations)*

- **Cognition & Intellectual Functioning** *(e.g. orientation to time/place/person, memory, attention/concentration, planning)*
  
  Indicate if **Cognitive Assessment (RUDAS)** or **3MS/MMS** completed  
  
  - [ ] No  
  - [x] Yes  
  - [ ] N/A

- **Insight and Judgement**

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**Staff Name:**

**Signature:**

**Designation:**

**Date:**
<table>
<thead>
<tr>
<th>Measure</th>
<th>Score/summary</th>
<th>Comment</th>
</tr>
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<tbody>
<tr>
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</tbody>
</table>

**FORMULATION/OVERALL CLINICAL IMPRESSION** (include current and longer term risk; document any 'Alert/Risks' on Page 1)

Staff Name: Signature: Designation: Date:

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Mental Health

ASSESSMENT

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

SURNAME

OTHER NAMES

MRN

□ MALE □ FEMALE

D.O.B. ______ / ______ / ______

M.O.

ADDRESS

LOCATION

PROVISIONAL DIAGNOSES

INITIAL MANAGEMENT PLAN

Has the Plan been discussed with a Consultant Psychiatrist/Senior Clinician?

No □ Yes □ N/A □

Name: __________________________ Date: ____________ Time: ____________

CONTACTS

Has a primary carer been identified under the Mental Health Act 2007

No □ Yes □ N/A □

Communication undertaken with

Yes □ Primary carer / family

Yes □ General Practitioner

Yes □ NGO / Other (specify)

Staff Name: __________________________ Signature: ____________ Designation: ____________ Date: ____________

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## Goal / Clinical issue 1

### Strategies / Interventions

<table>
<thead>
<tr>
<th>Person / service responsible</th>
<th>Target date</th>
<th>Review date &amp; rating</th>
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</thead>
<tbody>
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</table>

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### Goal / Clinical issue 2

### Strategies / Interventions

<table>
<thead>
<tr>
<th>Person / service responsible</th>
<th>Target date</th>
<th>Review date &amp; rating</th>
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</table>

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### Goal / Clinical issue 3

### Strategies / Interventions

<table>
<thead>
<tr>
<th>Person / service responsible</th>
<th>Target date</th>
<th>Review date &amp; rating</th>
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<tbody>
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The identified goals are to be developed:
(a) in collaboration with the consumer and/or primary carer(s) and
(b) considering significant scores on the HoNOS/HoNOSCA, LSP, K10 items etc

Review rating scale:
1 = Achieved / Resolved
2 = Improved
3 = Stable / No change
4 = Deteriorated

Consider changes in routine outcome measures scores in determining the review rating.

---

Mental Health

CARE PLAN

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SMR060.500
# CARE PLAN

## Goal / Clinical issue 4

<table>
<thead>
<tr>
<th>Strategies / Interventions</th>
<th>Person / service responsible</th>
<th>Target date</th>
<th>Review date &amp; rating</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

**Signature:**

**Designation:**

## Goal / Clinical issue 5

<table>
<thead>
<tr>
<th>Strategies / Interventions</th>
<th>Person / service responsible</th>
<th>Target date</th>
<th>Review date &amp; rating</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tr>
</tbody>
</table>

**Persons / services involved in the care planning process**

<table>
<thead>
<tr>
<th>Name &amp; Role</th>
<th>Contact Numbers</th>
<th>Name &amp; Role</th>
<th>Contact Numbers</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

**Consumer signature**

**Date**

**Primary carer Signature**

**Date**

**CP read & discussed**

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tr>
</tbody>
</table>
**Mental Health Site REVIEW**

Date: __________  Reason for review: __________

**SUMMARY OF CARE PROVIDED SINCE LAST ASSESSMENT/REVIEW**

includes psychological interventions etc

Has a physical examination occurred since last review? (document key findings, location info below e.g. GP letter, Physical Examination module)  

<table>
<thead>
<tr>
<th></th>
<th>Y</th>
<th>N</th>
<th>NA</th>
</tr>
</thead>
</table>

Current medications (note generic name)

<p>| |</p>
<table>
<thead>
<tr>
<th></th>
</tr>
</thead>
</table>

**SUMMARY OF PROGRESS AND CURRENT STATUS**

may include MSE and any changes in risk since assessment / last review)

Have any additional modules been completed e.g. Risk Assessment? (document the modules, completion dates and findings below)  

<table>
<thead>
<tr>
<th></th>
<th>Y</th>
<th>N</th>
<th>NA</th>
</tr>
</thead>
</table>

**RISK ASSESSMENT**  

Y=Yes, N=No, UK=Unknown

<table>
<thead>
<tr>
<th>Risk Factor</th>
<th>Suicide</th>
<th>Violence</th>
<th>Other*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Y N UK</td>
<td>Y N UK</td>
<td>Y N UK</td>
<td></td>
</tr>
</tbody>
</table>

Significant past history of risk
Recent thoughts, plans, symptoms indicating risk
Recent behaviour suggesting risk
Concern from others about risk (assessment should include corroboration where possible)
Current problems with alcohol or substance misuse
Major mental illness or disorder
At risk mental state (e.g. depressed, hopelessness, despair, guilt, marked agitation, disorganisation, intoxication)
Person’s level of risk appears to be highly changeable
Significant uncertainty in the assessment of the level of risk

Considering the above factors and information available from your assessment, is a more detailed assessment of suicide or violence risk required?  

‘Yes’ to any of the above risks factors may indicate that a more detailed assessment is required).  
Indicate if Risk Assessment module has been completed  

<table>
<thead>
<tr>
<th>Overall Level Of Risk</th>
<th>High</th>
<th>Med</th>
<th>Low</th>
</tr>
</thead>
<tbody>
<tr>
<td>Suicide</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Violence</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other* (specify)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Consider other risks such as child safety, absconding, exploitation, domestic violence, abuse, neglect, homelessness, serious drug reactions, falls

Staff Name:  
Signature:  
Designation:  
Date: 

---

MH_OAT Review.indd   1  21/08/2008   3:37:26 PM
ACTION PLAN FOLLOWING THE REVIEW (summarise in Care Plan as appropriate)

<table>
<thead>
<tr>
<th>ISSUE / PROBLEM</th>
<th>PLAN</th>
<th>PERSON / SERVICE RESPONSIBLE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

NEXT REVIEW DATE:

CONTACTS

Communication undertaken with Name Contact details Comment (note if involved in Review)

Yes Consumer
Yes Primary carer/family
Yes Psychiatrist/Senior Clinician
Yes General practitioner
Yes NGO/Other (specify)

Staff Name: Signature: Designation: Date:

MEASURES (e.g. routine outcome measures such as the HoNOS/HoNOSCA, LSP, K10 etc; other scales and tools; attach copies)

<table>
<thead>
<tr>
<th>Measures</th>
<th>Score / summary</th>
<th>Comment (Note changes since assessment / last review)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

CONSUMER / CARER VIEWS OF PROGRESS (note perceptions of what has and has not changed and contributing factors)

FORMULATION (consider current / immediate and longer term risk; summarise status in Care Plan as appropriate)

REVIEW COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

SURNAME MRN
OTHER NAMES
D.O.B. _____ / _____ / _______ M.O.
ADDRESS
LOCATION

MH_OAT Review.indd   2
21/08/2008   3:37:26 PM
Mental Health Site

TRANSFER / DISCHARGE SUMMARY

Consumer current contact numbers: ___________________________  Admission date: ___________________________

____________________________  Transfer / Discharge date: ___________________________

Transferred / Discharged to: ______________________________________________

Communication Issues (e.g. language, cultural barriers, sensory impairment) ______________________________________________

CURRENT RISK / SAFETY ISSUES

Suicide  □  □  □
Violence  □  □  □
Other* (specify)  □  □  □
Other* (specify)  □  □  □
Comments ______________________________________________

REASON FOR REFERRAL / ADMISSION

SUMMARY OF CARE PROVIDED AND OUTCOMES (e.g. what worked, what did not work and contributing factors)

__________________________________________________________

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__________________________________________________
## CURRENT MEDICATIONS
(document any allergies and adverse drug reactions in 'comments')

<table>
<thead>
<tr>
<th>Name (use generic)</th>
<th>Dose / frequency / route</th>
<th>Supply</th>
<th>Comment (e.g. side effects, allergies, adherence)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

**Depot last injection:** / / 
**Depot next due:** / / 
**Last injection site:** 

**Medications recently ceased** (document reasons)

**Allergies and adverse drug reactions**

**Legal status at transfer discharge**

- No Act Applies
- Community Treatment order
- Involuntary patient orders
- Guardianship
- Other

**Comments / Expiry date**

## MEASURES
(e.g. routine outcome measures such as the HoNOS, SDQ, RUGADL, other scales and tools. Attach copies where appropriate)

<table>
<thead>
<tr>
<th>Measure</th>
<th>Admission score</th>
<th>Discharge score</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

## CURRENT ISSUES AND RECOMMENDED FOLLOW UP TREATMENT / ACTIONS

<table>
<thead>
<tr>
<th>ISSUE / PROBLEM</th>
<th>PLAN</th>
<th>PERSON / SERVICE RESPONSIBLE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>

## CONTACTS

<table>
<thead>
<tr>
<th>Role / Service</th>
<th>Name</th>
<th>Contact details</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary carer / family</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other (specify)</td>
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<td></td>
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</tbody>
</table>

**Clinicians who provided care during the current episode**

- Care Coordinator
- Registrar
- Consultant
- Other (specify)

**Service provider who will be undertaking follow up**

- Details of appointment made (Date, time etc)

- General practitioner
- NGO / Other (specify)

**Staff Name:**  
**Signature:**  
**Designation:**  
**Date:**  

---

**Mental Health**

**TRANSFER / DISCHARGE SUMMARY**

**Site**

**COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE**

---

**Obslete**
**GENERAL APPEARANCE AND OBSERVATIONS**

<table>
<thead>
<tr>
<th>Pulse</th>
<th>Height (m)</th>
<th>Waist (cm)</th>
<th>Lying</th>
<th>Standing</th>
</tr>
</thead>
<tbody>
<tr>
<td>BP</td>
<td>Weight (kg)</td>
<td>Hips (cm)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Temp</td>
<td>BMI (kg/m²)</td>
<td>Waist/Hip ratio</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Resp</td>
<td>BSL (mmol/L)</td>
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<td></td>
</tr>
</tbody>
</table>

Urinalysis: N □ Y □ N/A □ Results: 

Other observation or available investigations (e.g. hearing and visual difficulties):

Staff Name: Signature: Designation: Date:

**SYSTEM REVIEW**

(e.g. relevant positive or negative history or symptoms)

**CARDIOVASCULAR**

**RESPRATORY**

**GASTROINTESTINAL**

**NEUROLOGICAL**

Consciousness

Pupils

Cranial nerves

Power

Sensation

Tone

Reflexes

Gait

Medical officer name: Signature: Date:
Abnormal involuntary movement scale (AIMS)

Rate highest severity observed. Rate movements that occur upon activation one less than those observed spontaneously. Circle movement, as well as rating score, that applies.

Rating score:                      0 = none          1 = minimal          2 = mild          3 = moderate          4 = severe

<table>
<thead>
<tr>
<th>Facial and oral movements</th>
<th>0    1    2    3    4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Muscles of facial expression</td>
<td>0    1    2    3    4</td>
</tr>
<tr>
<td>Lips and perioral area</td>
<td>0    1    2    3    4</td>
</tr>
<tr>
<td>Extremity movements</td>
<td>0    1    2    3    4</td>
</tr>
<tr>
<td>Upper (arms, wrists, hands, fingers)</td>
<td>0    1    2    3    4</td>
</tr>
<tr>
<td>Lower (legs, knees, ankles, toes)</td>
<td>0    1    2    3    4</td>
</tr>
<tr>
<td>Neck, shoulders, hips</td>
<td>0    1    2    3    4</td>
</tr>
</tbody>
</table>

AIMS SUBTOTAL

Global judgements

Severity of abnormal movements overall | 0    1    2    3    4  |
Incapacitation due to abnormal movements | 0    1    2    3    4  |
Patient's awareness of abnormal movements | 0    1    2    3    4  |

Current problems with teeth and/or dentures: Yes ☐ No ☒
Are dentures usually worn: Yes ☐ No ☒
Movements disappear in sleep: Yes ☐ No ☒

Comments (consider abnormal tone / evidence of akathisia)

ADDITIONAL EXAMINATION (e.g. other relevant systems, infectious diseases)

Pregnancy status (if applicable): □ Not pregnant □ Pregnant □ Unknown

OVERALL IMPRESSION

IMMEDIATE ACTIONS (e.g. investigations ordered, urgent treatment, consults requested)

Medical officer name:       Signature:       Date:
This module provides a more structured way of documenting physical appearance. If completed at assessment, its completion should be recorded in the Assessment module under ‘Physical examination summary’.

### PHYSICAL DESCRIPTION

<table>
<thead>
<tr>
<th>Category</th>
<th>Options</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Body build</strong></td>
<td>Obese, Muscular, Medium, Solid, Thin, Other</td>
</tr>
<tr>
<td><strong>Complexion</strong></td>
<td>Olive, Ruddy, Fair, Sallow, Cyanotic, Other</td>
</tr>
<tr>
<td><strong>Facial hair</strong></td>
<td>Yes (describe)</td>
</tr>
<tr>
<td><strong>Teeth</strong></td>
<td>Type: None, Primary, Permanent, Braces, Dentures</td>
</tr>
<tr>
<td><strong>Condition</strong></td>
<td>Good, Poor</td>
</tr>
<tr>
<td><strong>Hair</strong></td>
<td>Colour: Black, Brown, Blonde, Grey, Auburn, Dyed</td>
</tr>
<tr>
<td></td>
<td>White, Red / ginger, Multi, Light brown, Other</td>
</tr>
<tr>
<td><strong>Length / style</strong></td>
<td>Short, Medium, Long, Bald, Curly, Straight</td>
</tr>
<tr>
<td><strong>Eyes</strong></td>
<td>Colour: Blue, Brown, Green, Hazel, Grey</td>
</tr>
<tr>
<td></td>
<td>Blue / grey, Grey / hazel, Other</td>
</tr>
<tr>
<td><strong>Sight</strong></td>
<td>Good, Poor</td>
</tr>
<tr>
<td><strong>Aids</strong></td>
<td>Glasses, Contact lens: Unifocal, Bifocal</td>
</tr>
<tr>
<td><strong>Hearing</strong></td>
<td>Adequate, Impaired, Hearing aid, Deaf</td>
</tr>
</tbody>
</table>

### Additional comments

---

Staff Name: Signature: Designation: Date:
This module is designed to assist clinicians to formulate current risk where a face-to-face assessment has already been completed and corroborative information obtained. This module may be used at Assessment, Review and Discharge. Please attach to relevant base module and summarise findings in relevant components of the appropriate MH-OAT base module/s e.g. if completed at Assessment, summarise in Formulation on page 7.

### GENERAL RISK FACTORS

<table>
<thead>
<tr>
<th>Factor</th>
<th>Y</th>
<th>N</th>
<th>UK</th>
<th>Current factor</th>
<th>Y</th>
<th>N</th>
<th>UK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Major psychiatric illness</td>
<td></td>
<td></td>
<td></td>
<td>Disorientation or disorganisation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diagnosed Personality Disorder</td>
<td></td>
<td></td>
<td></td>
<td>Disinhibition, intrusive/impulsive behaviour</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Significant alcohol/drug abuse history</td>
<td></td>
<td></td>
<td></td>
<td>Current intoxication/withdrawal</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Serious medical condition</td>
<td></td>
<td></td>
<td></td>
<td>Significant physical pain</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intellectual disability/cognitive deficits</td>
<td></td>
<td></td>
<td></td>
<td>Other (specify)</td>
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<tr>
<td>Significant behavioural disorder (&lt;18 years)</td>
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<tr>
<td>Other (specify)</td>
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</table>

### SUICIDE

<table>
<thead>
<tr>
<th>Factor</th>
<th>Y</th>
<th>N</th>
<th>UK</th>
<th>Current factor</th>
<th>Y</th>
<th>N</th>
<th>UK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Previous suicide attempts</td>
<td></td>
<td></td>
<td></td>
<td>Recent significant life events</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>History of other self harm</td>
<td></td>
<td></td>
<td></td>
<td>Hopelessness/despair</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family history of suicide</td>
<td></td>
<td></td>
<td></td>
<td>Expressing high levels of distress</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Separated/widowed/divorced</td>
<td></td>
<td></td>
<td></td>
<td>Expressing suicidal ideas</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Isolation/lack of role</td>
<td></td>
<td></td>
<td></td>
<td>Self-harming behaviour</td>
<td></td>
<td></td>
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<tr>
<td>Other (specify)</td>
<td></td>
<td></td>
<td></td>
<td>Current plan/intent</td>
<td></td>
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<tr>
<td>Other (specify)</td>
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</tbody>
</table>

### VIOLENCE/AGGRESSION

<table>
<thead>
<tr>
<th>Factor</th>
<th>Y</th>
<th>N</th>
<th>UK</th>
<th>Current factor</th>
<th>Y</th>
<th>N</th>
<th>UK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Previous incidents of violence</td>
<td></td>
<td></td>
<td></td>
<td>Recent/current violence</td>
<td></td>
<td></td>
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<tr>
<td>Previous use of weapons</td>
<td></td>
<td></td>
<td></td>
<td>Command hallucinations</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Criminal history</td>
<td></td>
<td></td>
<td></td>
<td>Paranoid ideation about others</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Previous dangerous/violent ideation</td>
<td></td>
<td></td>
<td></td>
<td>Expressing intent to harm others</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Childhood abuse/maladjustment</td>
<td></td>
<td></td>
<td></td>
<td>Anger, frustration or agitation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>History of predatory behaviour</td>
<td></td>
<td></td>
<td></td>
<td>Reduced ability to control behaviour</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Other (specify)</td>
<td></td>
<td></td>
<td></td>
<td>Access to available means</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other (specify)</td>
<td></td>
<td></td>
<td></td>
<td>Contact with vulnerable person/s</td>
<td></td>
<td></td>
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<tr>
<td>Other (specify)</td>
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</tbody>
</table>

### COMMENTS

Staff Name: ___________ Signature: ___________ Designation: ___________ Date: ___________
**OTHER VULNERABILITIES**

<table>
<thead>
<tr>
<th>Background factors</th>
<th>Y</th>
<th>N</th>
<th>UK</th>
<th>Current factors</th>
<th>Y</th>
<th>N</th>
<th>UK</th>
</tr>
</thead>
<tbody>
<tr>
<td>History of absconding</td>
<td></td>
<td></td>
<td></td>
<td>Desire/intent to leave hospital</td>
<td></td>
<td></td>
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<tr>
<td>History of sexual vulnerability</td>
<td></td>
<td></td>
<td></td>
<td>Vulnerability to sexual exploitation/abuse</td>
<td></td>
<td></td>
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<tr>
<td>History of financial vulnerability</td>
<td></td>
<td></td>
<td></td>
<td>Current delusional beliefs</td>
<td></td>
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<tr>
<td>(eg gambling)</td>
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<td></td>
<td></td>
<td>Physical illness</td>
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<tr>
<td>History of falls</td>
<td></td>
<td></td>
<td></td>
<td>Parental/carer status or access to children</td>
<td></td>
<td></td>
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<tr>
<td>History of harm to children</td>
<td></td>
<td></td>
<td></td>
<td>Self neglect, poor self care etc</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Other (specify)</td>
<td></td>
<td></td>
<td></td>
<td>Non-adherence to medications/treatment</td>
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<td>Other (specify)</td>
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</table>

**COMMENTS**


**OVERVIEW / IMPRESSION**

<table>
<thead>
<tr>
<th>Y</th>
<th>N</th>
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<tbody>
<tr>
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</tbody>
</table>

- Is this person's level of risk highly changeable?  
- Are there factors that contribute to uncertainty regarding the level of risk?

**PROTECTIVE FACTORS**  
(e.g. insightful, engaged with services)


**OVERALL ASSESSMENT OF RISK**

<table>
<thead>
<tr>
<th>High</th>
<th>Med</th>
<th>Low</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

- Suicide
- Self harm
- Violence/aggression
- Vulnerability
- Absconding
- Other (specify)

**COMMENTS**


**SPECIFIC RISK ISSUES TO BE ADDRESSED IN MANAGEMENT/CARE PLAN**

(consider current/immediate and longer term risk)


Staff Name:  
Signature:  
Designation:  
Date:
This module can be used at any point of care; attach to relevant base module and summarise in relevant components. For example, if completed at assessment, please attach to Assessment module and summarise findings in Drug and Alcohol History on page 2.

<table>
<thead>
<tr>
<th>Substance / drug type</th>
<th>Last used? (date, time)</th>
<th>Usual amount?</th>
<th>How often? (e.g. 4 times a day, weekly)</th>
<th>Duration of use</th>
<th>Route? (e.g. oral, injection)</th>
<th>Withdrawal risk (low-high)*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol</td>
<td></td>
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<td></td>
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<tr>
<td>Tobacco</td>
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<tr>
<td>Benzodiazepines</td>
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<tr>
<td>Cannabis</td>
<td></td>
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<tr>
<td>Amphetamines</td>
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<tr>
<td>Cocaine</td>
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<tr>
<td>MDMA (Ecstasy)</td>
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<tr>
<td>Heroin</td>
<td></td>
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<td></td>
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<tr>
<td>Prescription analgesics</td>
<td></td>
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<tr>
<td>Methadone</td>
<td></td>
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<tr>
<td>Buprenorphine</td>
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<tr>
<td>Solvents</td>
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<tr>
<td>Hallucinogens</td>
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<td></td>
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<tr>
<td>Other (Specify)</td>
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</tr>
</tbody>
</table>

*Note below previous withdrawal experiences, types of symptoms and any complications

**COMMENTS / ADDITIONAL INFORMATION**

E.g. related harms: physical, relationships, employment, finances, legal; gambling problems; readiness for change; factors influencing use; relapse factors

---

Staff Name: Signature: Designation: Date:
## OVERVIEW
(tick or comment if dependence and/or abuse factors relevant in last 12 months)

### DEPENDENCE

**Tolerance**

**Withdrawal**

- Use more / longer than intended
- Inability or persistent desire to cut down
- Excess time obtaining/using/recovering
- Important activities given up
- Use despite physical/psychological problems

<table>
<thead>
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</table>

### ABUSE

- Failure to fulfil obligations
- Use in hazardous situations
- Legal problems
- Use despite social and interpersonal problems

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<th>3</th>
</tr>
</thead>
</table>

### SPECIFIC ISSUES TO BE ADDRESSED IN MANAGEMENT / CARE PLAN

Consider current/immediate and longer term issues; consider implications of any episodic or ongoing cognitive impairment.

---

**Note that risky drinking limits may be lower for pregnant women, the elderly and other relevant groups who should drink less.**

Mental health professionals seeking information and advice should (1) contact your local Alcohol and Other Drug specialist/service or (2) contact ADIS who provide advice to mental health professionals on illegal drug and alcohol use on:

- Sydney Metro 9361 8000
- Country 1800 422 599

Staff Name:  
Signature:  
Designation:  
Date:  

---

**SMR025.040 Page 2 of 2**
**CURRENT PARENTAL/CARER FUNCTIONING: SYMPTOMS, BEHAVIOUR THAT MAY IMPACT ON THE CHILD**

**BEHAVIOUR**

- Clinically significant behavioural disturbance (e.g. disorganised, obsessive-compulsive rituals)
- Behaviour frightens, confuses or embarrasses the child
- Other (specify)

**MOOD AND AFFECT**

- Clinically significant affect disturbance (e.g. emotionally withdrawn, inappropriate, flat, restricted, labile)
- Child is witnessing significant irritability/anger (e.g. marital disharmony, domestic violence)
- Other (specify)

**SPEECH, THOUGHT, PERCEPTION AND COGNITION**

- Delusional thinking targets and incorporates child
- Hallucinations target and incorporate child
- Other (specify)

**INSIGHT AND JUDGEMENT**

- Lacks insight into their illness
- Treatment non-adherent (e.g. non-attendance of appointments, poor engagement)
- Other (specify)

**COMORBIDITY**

- Abuses alcohol or drugs
- Has a diagnosed personality or other mental disorder
- Other (specify)

**SELF REPORTED PARENTAL/CARER CONCERNS**

- Concerned about their ability to meet the needs of the child, including safety
- Concerned about the impact of their mental illness/disorder on the child (e.g. neglect, irritability)
- Concerns about their partner/spouse (e.g. domestic violence)
- Concerns about the amount and quality of social support (e.g. social isolation)
- Other (specify)

**CHILD’S CURRENT FUNCTIONING**

**PHYSICAL AND PSYCHOSOCIAL HEALTH AND DEVELOPMENT**

- Concerns about:
  - Child’s health, growth and physical development
  - Child’s cognitive and language development
  - Recent changes in the child’s behaviour (e.g. bedwetting, oppositional, clingy, withdrawn, angry)
  - Impacts of recent life event/s on child (e.g. hospitalisation, illness, bereavement)
  - Child’s educational attainment (consider school attendance)
  - Child’s emotional and behavioural development
  - Child’s identity and self esteem (e.g. shame re parent’s illness, feelings of inadequacy)
  - Family and social relationships (e.g. conflict, level of warmth and support)
  - Social skills, self-care and general presentation
- Other (specify)

**SELF REPORTED CONCERNS**

- Concerns about their parent’s/carer’s illness (e.g. anxiety, anger, confusion, guilt, lack of understanding)
- Concerns about the nature and amount of their own carer responsibilities (e.g. looking after parent, siblings)
- Other (specify)

**CONCERNS EXPRESSED BY OTHERS REGARDING CHILD’S WELLBEING & SAFETY**

- Concerns have been expressed
- Specify:

**Staff Name:**

**Signature:**

**Designation:**

**Date:**
### SUMMARY OF CHILD, PARENT/CARER AND FAMILY RISK AND PROTECTIVE FACTORS

This page assists in the collation and analysis of assessment information and determination of urgency of response. Please attach to relevant base module and summarise findings in relevant components e.g. if completed at assessment, document in ‘Risk Assessment’, ‘Formulation’ and ‘Initial Management Plan’.

<table>
<thead>
<tr>
<th>KEY DOMAINS</th>
<th>STRENGTHS/PROTECTIVE FACTORS</th>
<th>VULNERABILITIES/ RISK FACTORS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parental/carer mental health history</td>
<td>e.g. insightful, good treatment adherence</td>
<td>e.g. lacks insight, poor treatment adherence</td>
</tr>
<tr>
<td>Parental/carer drug and alcohol history</td>
<td>e.g. current substance use/abuse status, level of engagement with AOD services, level of insight, response to treatment</td>
<td></td>
</tr>
<tr>
<td>Family medical history (consider parental and child issues)</td>
<td>e.g. significant chronic or acute medical illness, treatment adherence, response to treatment</td>
<td></td>
</tr>
<tr>
<td>Parental/carer background and childhood (parent's/carer's family of origin experiences)</td>
<td>e.g. cultural issues, childhood trauma, adversity &amp; loss, stability &amp; quality of care received as a child, social/recreational functioning, educational functioning</td>
<td></td>
</tr>
<tr>
<td>Child's developmental and personal history</td>
<td>e.g. perinatal &amp; childhood development, past social/recreational functioning, intellectual/cognitive functioning, past abuse/neglect experiences</td>
<td></td>
</tr>
<tr>
<td>Parental/carer current functioning and supports</td>
<td>e.g. financial &amp; employment status, parenting skills, social &amp; other supports, marital/inter-parental relationship, parent-child relationship, past DoCS notification</td>
<td></td>
</tr>
<tr>
<td>Child's current functioning and supports</td>
<td>e.g. exposure to parental symptoms/behaviour, living situation, family relationships &amp; other supports, peer relations, educational functioning, self esteem, age appropriate responsibilities, role models</td>
<td></td>
</tr>
</tbody>
</table>

### OVERVIEW

- Parent/carer's current symptoms and behaviour interfere with undertaking parental and/or essential household duties: [ ] Yes  [X] No
- Parent/carer's current symptoms and behaviour is having a negative impact on the child: [ ] Yes  [X] No

### SPECIFIC ISSUES TO BE ADDRESSED IN MANAGEMENT/CARE PLAN (Consider current & longer term issues)

- 
- 

Staff Name: __________________________ Signature: __________________________ Designation: __________________________ Date: __________________________
This module assists the identification of functional abilities in an aged care consumer. It may be used at assessment, review and discharge. Please attach to relevant base module and summarise findings in relevant components e.g. if completed at assessment, document in ‘Current functioning and supports’.

**ACTIVITIES OF DAILY LIVING**

(please tick)

<table>
<thead>
<tr>
<th>Function</th>
<th>Independent</th>
<th>Initial set up/ preparation</th>
<th>1 person assist</th>
<th>2 person assist</th>
<th>&gt; 2 person assist</th>
<th>Comment / use of aids</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bathing</td>
<td></td>
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<tr>
<td>Mobility</td>
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<tr>
<td>Mobility in Bed</td>
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<tr>
<td>Transfer</td>
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<tr>
<td>Toileting</td>
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<tr>
<td>Incontinence</td>
<td>Continent</td>
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<tr>
<td>Eating</td>
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<tr>
<td>Other (specify)</td>
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</tbody>
</table>

**Sleep**

Pattern

**Nutrition**

Special requirements

**Falls risk factors present**

(please tick applicable factors)

- Previous falls
- Cognitive impairment
- Visual impairment
- Environmental factors
- Incontinence
- Medication effects
- Physical / medical

**COMMENTS** (consider strengths/skills & deficits etc)

**INSTRUMENTAL ACTIVITIES OF DAILY LIVING**

(please tick)

<table>
<thead>
<tr>
<th>Activity</th>
<th>Independent</th>
<th>Limited assist</th>
<th>Significant assist</th>
<th>Comment</th>
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</thead>
<tbody>
<tr>
<td>Money management</td>
<td></td>
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<tr>
<td>Medication management</td>
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<tr>
<td>Telephone use</td>
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<td>Travel / transport</td>
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<td>Shopping</td>
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<tr>
<td>Cooking</td>
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<tr>
<td>Washing</td>
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<tr>
<td>Housework</td>
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<tr>
<td>Maintenance</td>
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<tr>
<td>Gardening</td>
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<tr>
<td>Pet care</td>
<td></td>
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<tr>
<td>Other (specify)</td>
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**COMMENTS** (consider strengths/skills & deficits etc)

Staff Name: __________________________

Signature: __________________________

Designation: __________________________

Date: __________________________
# Functional Assessment (Older People)

**Social and Recreational Functioning**

*E.g. social skills, level of social activity, social isolation, connectedness with family and other relationships, level of other supports*

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**Level of Assistance Required to Engage with Health Services / Other Agencies**

*E.g. attendance at appointments, compliance with medication, level of cooperation with management / care, level of assertive follow up required*

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**Other**

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**Issues to Be Addressed in Management / Care Plan** *(consider strengths / skills & deficits)*

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Staff Name:  
Signature:  
Designation:  
Date:  

---
For females aged 16 or over, the completion of the Screening For Domestic Violence is mandatory. Attach completed module to Assessment module and summarise findings under ‘Alerts/Risks’ on page 1, ‘Current Functioning and Supports’ on page 5, ‘Risk Assessment’ on page 7 and ‘Initial Management Plan’ on page 8.

The domestic violence routine screening tool is to be used with women aged 16 and over and in accordance with screening protocols and the NSW Health Policy and Procedures for Identifying and Responding to Domestic Violence.

YOU MUST EXPLAIN THIS TO THE WOMEN BEING INTERVIEWED:

- “In this Health Service we ask all women the same questions about violence at home.”
- “This is because violence in the home is very common and can be serious and we want to improve our response to women experiencing domestic violence.”
- “You don’t have to answer the questions if you don’t want to.”
- “What you say will remain confidential to the Health Service except where you give us information that indicates that there are serious safety concerns for you or your children.”

SCREENING QUESTIONS:

1. “Within the last year have you been hit, slapped or hurt in other ways by your partner or ex-partner?”
2. “Are you frightened of your partner or ex-partner?”

If the woman answers NO to both questions, give the information card to her and say:

“Here is some information that we are giving to all women about domestic violence.”

If the woman answers YES to either or both of the above questions continue to question 3 and 4.

3. “Are you safe to go home/Are you safe here at home?”
4. “Would you like some assistance with this?”

Consider safety concerns raised in answers to questions.

ACTION TAKEN: SCREENING WAS NOT COMPLETED DUE TO:

- Domestic violence identified, information given
- Domestic violence identified, information declined
- Domestic violence not identified, information given
- Domestic violence not identified, information declined
- Support given and options discussed
- Reported to DoCS
- Police notified
- Referral made to

- Other action taken

- Other reason/s, please specify: __________________________

Staff Name: __________________________ Signature: __________________________ Date: __________________________
The Rowland Universal Dementia Assessment Scale (RUDAS) (Storey et al., 2002) is designed to assess cognition. It can be used during the assessment of the consumer at any point of care. If completed at assessment, document under ‘Mental State Examination’ ‘Cognition & intellectual functioning’. Any score derived from its use requires clinical interpretation. N.B. Italics in the module indicate instructions read to the consumer.

**MEMORY**

1. “I want you to imagine that we are going shopping. Here is a list of grocery items. I would like you to remember the following items which we need to get from the shop. When we get to the shop in about 5 minutes time I will ask you what it is that we have to buy. You must remember the list for me.”

Tea, Cooking Oil, Eggs, Soap

*Please repeat this list for me* (Ask person to repeat the list 3 times). (If person did not repeat all four words, repeat the list until the person has learned them and can repeat them, or, up to a maximum of 5 times).

**VISUOSPATIAL ORIENTATION**

2. “I am going to ask you to identify/show me different parts of the body.” (Correct=1).

Once the person correctly answers 5 parts of this question do not continue as the maximum score is 5.

1. Show me your right foot 1
2. Show me your left hand 1
3. With your right hand touch your left shoulder 1
4. With your left hand touch your right ear 1
5. Which is (indicate/point to) my left knee 1
6. Which is (indicate/point to) my right elbow 1
7. With your right hand indicate/point to my left eye 1
8. With your left hand indicate/point to your right ear 1

**PRAXIS**

3. “I am going to show you some exercises with my hands. I want you to watch me and copy what I do. Copy me when I do this…” (One hand in fist, the other palm down on table - alternate simultaneously). “Now do it with me: Now I would like you to keep doing this action at this pace until I tell you to stop - approximately 10 seconds” (Demonstrate at moderate walking pace)

Score as:
- Normal=2 (very few if any errors; self-corrected, progressively better; good maintenance; only very slight lack of synchrony between hands)
- Partially adequate=1 (noticeable errors with some attempt to self-correct; some attempt at maintenance; poor synchrony)
- Failed=0 (cannot do the task; no maintenance; no attempt whatsoever)

**VISUO-CONSTRUCTIONAL DRAWING**

4. “Please draw this picture exactly as it looks to you” (Show cube on last page). (Yes=1)

Score as:
1. Has person drawn a picture based on a square? 1
2. Do all internal lines appear in person’s drawing? 1
3. Do all external lines appear in person’s drawing? 1
5. "You are standing on the side of a busy street. There is no pedestrian crossing and no traffic lights. Tell me what you would do to get across to the other side of the road safely." (If the person gives an incomplete response that does not address both parts of the answer, use prompt: "Is there anything else you would do?"). Below, record exactly what the person says and circle all parts of response which were prompted.

Score as:
Did person indicate that they would look for traffic? (Yes=2; Yes prompted=1; No=0) 2
Did person make any additional safety proposals? (Yes=2; Yes prompted=1; No=0) 2

6. (Recall) "We have just arrived at the shop. Can you remember the list of groceries we need to buy?" (Prompt: If person cannot recall any of the list, say "The first one was 'tea'".) (Score 2 points each for any item recalled which was not prompted - use only 'tea' as a prompt.)

Tea 2
Cooking Oil 2
Eggs 2
Soap 2

TOTAL SCORE (out of 8) *W below 23 indicates likely cognitive impairment

CLINICAL OVERVIEW / ISSUES TO BE ADDRESSED IN MANAGEMENT / CARE PLAN (consider all cognitive testing)
The Modified Mini-Mental State (3MS) was developed by Teng & Chui (1987) to assess cognition. It can be used during the assessment of the consumer at any point of care. If completed at assessment, document under ‘Mental State Examination’ ‘Cognition & intellectual functioning’. Any score derived from its use requires clinical interpretation.

*Shaded items highlight the MMS approximation. N.B. Italics in the module indicate instructions read to the consumer.

**DATE and PLACE OF BIRTH**

**SCORE:** 3MS MMS*

**REGISTRATION**

Say the 3 words listed below, then ask the person to repeat them. Repeat until correct but only score the first attempt.

- SHIRT, BROWN, HONESTY
  (or: SHOES, BLACK, MODESTY)
  (or: SOCKS, BLUE, CHARITY)

Note number of presentations:

- 3

**MENTAL REVERSAL***

Ask the person to count backwards from 5 to 1

- Accurate
- 1 or 2 errors / misses

Ask the person to spell ‘world’ backwards

- DLROW

*MMS uses serial 7’s. Stop after 5 answers. Give one point for each correct answer.

**FIRST RECALL**

Ask the person to recall the 3 words previously stated (unprompted)**

Spontaneous recall of first word

- 3

If required prompt by saying ‘the first one is something to wear’

- 2

If required prompt by giving options: ‘SHIRT, SOCKS’

- 0 1

Spontaneous recall of second word

- 3

If required prompt by saying ‘the second one is a colour’

- 2

If required prompt by giving options: ‘BLUE, BLACK, BROWN’

- 0 1

Spontaneous recall of third word

- 3

If required prompt by saying: ‘the third one is a good personal quality’

- 2

If required prompt by giving options: ‘HONESTY, CHARITY, MODESTY’

- 0 1

**TEMPORAL ORIENTATION**

What is the Year?

- Accurate
- Missed by 1 year
- Missed by 2-5 years

What is the Season?

- Accurate or within 1 month
- 0 1

What is the Month?

- Accurate or within 5 days
- Missed by 1 month

What is the Day of the Month?

- Accurate
- Missed by 1 or 2 days
- Missed by 3-5 days

What is the Day of the Week?

- Accurate
- 0 1

N.B. for MMS give one point for each correct answer.

**SPATIAL ORIENTATION**

Where are we: State?

- 0 2

Where are we: Country?

- 0 1

Where are we: City /[town]?

- 0 4

Where are we: HOSPITAL / OFFICE BUILDING / HOME?

- 0 1

Staff Name: Signature: Designation: Date:

**OTHER COGNITIVE TESTS** (e.g. clockface drawing, trail making)
Ask the person to read and obey the following sentence.

CLOSE YOUR EYES

Ask the person to copy the design below. All 10 angles must be present and two must intersect to form a 4 sided figure. Tremor and rotation are ignored.

DRAWING AND WRITING BY CONSUMER

NAMING
Ask the person to name the following:

- Forehead
- Chin
- Shoulder
- Elbow
- Knuckle
- Shoulder

N.B. for MMS ask the person to only name the first two, for the 3MS ask all five.

FOUR-LEGGED ANIMALS (30 SECONDS) 1 POINT EACH
Ask the person to name as many 4 legged animals as they can in 30 seconds. The maximum score is 10.

SIMILARITIES
Ask the person how an Arm and Leg are similar.
- Correct answer: Body part, limb; etc.
- Less correct answer

Ask the person how Laughing and Crying are similar.
- Correct answer: Feeling; emotion
- Other correct answer

Ask the person how Eating and Sleeping are similar.
- Correct answer: Essential for life
- Other correct answer

REPETITION
Ask the person to repeat: "I WOULD LIKE TO GO HOME/OUT"
- 1 or 2 missed/wrong words

Ask the person to repeat: "NO IFS ANDS OR BUTS"
- N.B. That for the shaded component the 3MS scores 3 points for a correct answer, the MMS scores 1.

READ AND OBEY "CLOSE YOUR EYES"
Ask the person to read and obey the above sentence, which is located on page 3.
- Obeyes without prompting
- Obeyes after prompting (spontaneously or by request)

WRITING
Ask the person to write on the next page: (I) WOULD LIKE TO GO HOME/OUT
- N.B. For the MMS, score 1 if correct.

COPYING TWO PENTAGONS (1 minute)
Ask the person to copy the design on the next page.
- Scoring: 5 approximately equal sides
- Each pentagon
- 2 unequal (>2:1) sides
- Other enclosed figure
- 2 or more lines
- 4 corners
- Not-4-corners enclosure

THREE-STEP COMMAND
Ask the person to follow a 3 stage command: "Take a piece of paper in your left/right hand, fold it in half, and hand it back to me."
- N.B. Give one point for each stage correct.

SECOND RECALL
Ask the person to recall the 3 words (Something to wear) from page 1.
- Color
- Good personal quality

TOTAL SCORE
(3MS out of 100) (MMS out of 30)

MMS: normal >=27; Cognitive impairment: mild 22-26, moderate 17-19, severe <10. 3MS under 76 indicates likely cognitive impairment.

CLINICAL OVERVIEW/ISSUES TO BE ADDRESSED IN MANAGEMENT/CARE PLAN (consider all cognitive testing)
This module has been designed by consumers. All consumers are encouraged to complete it in partnership with their clinician and/or nominated carer. The intent of the module is to facilitate consumer involvement in their own care, particularly in terms of symptom management, relapse prevention and crisis planning. It serves as a recovery aid and as a prompt and reminder about what to do to support recovery.

**Things I do well / skills I have**

**Things I can do to keep myself well / what helps me stay well**

**Supports/ treatments / medications that have been helpful and / or I have liked (e.g. education, rehabilitation, CBT)**

**Supports/ treatments / medications that have been unhelpful and / or I have disliked (e.g. medication side effects)**

Consumer Name: Signature: Date:
**CONSUMER WELLNESS PLAN**

**Things that stress me**

<table>
<thead>
<tr>
<th>Things I can do to reduce stress</th>
</tr>
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<tbody>
<tr>
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</table>

**My early warning signs are**

<table>
<thead>
<tr>
<th>Things that help with early warning signs</th>
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**When I am unwell, I and / or others may notice that I.... (details of ‘others’ noted in ‘Contact details’)**

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**If I become unwell, I would like the following to happen or not to happen (e.g. care of children/ dependents/ pets, payment of bills, looking after my personal effects, contacting work or place of study, people I don’t want involved in my care)**

<table>
<thead>
<tr>
<th>Task / Issue</th>
<th>Who will do it / is responsible</th>
<th>When</th>
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<tbody>
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**Contact details of my nominated support people**

<table>
<thead>
<tr>
<th>Name</th>
<th>Relationship</th>
<th>Contact details</th>
<th>Input into Plan?*</th>
<th>Copy of Plan?**</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Family / Primary carer</td>
<td></td>
<td>Yes</td>
<td>No</td>
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<td></td>
<td>GP</td>
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<td>Yes</td>
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**REVIEW DATE:**

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<th>Copy provided to consumer</th>
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</thead>
<tbody>
<tr>
<td>I have been fully informed about my rights and responsibilities <em>(includes receipt of consumer package)</em></td>
</tr>
<tr>
<td>Yes</td>
</tr>
<tr>
<td>I have been informed of peer support options</td>
</tr>
<tr>
<td>Yes</td>
</tr>
</tbody>
</table>

Consumer Name: Signature: Date: