Please use I.D. label or block print

EMR317250

DISABILITY HEALTH PROFILE (ADMISSION INFORMATION)

CLINIC

CLINICIAN

SURNAME	UMRN	
GIVEN NAMES	DOB	GENDER
ADDRESS		POSTCODE
	TELEPHONE	

Admission Date		**NDIS Number**	
Reason for person attending hospital		NDIS Plan in place: ☐ Yes ☐ No NDIS Plan nominee: ☐ Yes ☐ No	Date of next plan review:
NOK aware of admission	☐ Yes ☐ No	**Support coordinator** Contact details:	
Name of NOK		**Service Provider/s:** *Request copy of care plan for the file*	
NOK Phone			
Is the individual able to make decisions independently? ☐ Yes ☐ No *If no, who supports them with decision making? Complete below:* ☐ Enduring Power of Attorney ☐ Enduring Power of Guardianship ☐ Administration Order ☐ Guardianship Order ☐ SAT in progress Hearing date *(if known)*: _____ Other: _____		**Funding source**	☐ NDIS ☐ MyAgedCare ☐ ICWA ☐ Worker's Compensation ☐ CAEP ☐ Other _____
Primary Language		**Interpreter required?**	☐ Yes ☐ No
Residential Status	☐ Own home ☐ Private rental ☐ Public rental ☐ Other: ☐ Lives alone ☐ Lives with others ☐ Formal supports (paid) ☐ Informal supports (unpaid) Details:		
Disability/s	☐ Physical ☐ Sensory ☐ Neurological ☐ Neurodivergent ☐ Intellectual ☐ Developmental ☐ Psychosocial Specify:		
Behaviour/s of Concern		**Positive Behaviour Support Plan** in place:	☐ Yes ☐ No *(if yes, request copy for file)* If yes, PBS practitioner details:
Cognition	Cognitive Impairment: ☐ Yes ☐ No Comments:		
Mental Health	Risk Assessment and Management Plan (RAMP) ☐ Yes ☐ No Treatment Support and Discharge Plan ☐ Yes ☐ No		
Communication	☐ Independent ☐ Assisted If assisted, details:		
Specialised Equipment		**Environmental Requirements** (Eg lighting, noise control and/or other)	

	Independent (tick)	Assisted (tick)	Comments (note level of assistance required and equipment needs)
Mobility	☐	☐	
Personal Care	☐	☐	
Toileting	☐	☐	
Eating / Drinking	☐	☐	
	Continent	**Incontinent**	**Comments (note any equipment / consumables required)**
Bladder	☐	☐	
Bowel	☐	☐	

Signature	Name	Designation	Phone / Pager	Date

DO NOT WRITE IN MARGIN

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07/23

MR267 DISABILITY HEALTH PROFILE (ADMISSION INFORMATION)