GOLD COAST HEALTH
Queensland Government

PHONE: 1300 130 143
FAX: 1300 130 588

AGED CARE ASSESSMENT TEAM
GOLD COAST
Email: gchacat@health.qld.gov.au

ACAT No: _____ **Referral Date:** ____/____/_____ **Time:** ____:_____ Previous ACAT Ax: ☐ Yes ☐ No
Team Completing: _____ Approvals: _____ Date: ____/____/_____

PERSON INITIATING REFERRAL: _____ Relationship/Status: _____
Address: _____ Post Code: _____
Email: _____ Fax: _____
Phone: (H) _____ (W) _____ (Mob) _____

CLIENT CONSENT TO REFERRAL: ☐ Yes ☐ No Who has consented? _____
Guardian/Capacity Issues: ☐ No ☐ Yes Guardian/EPOA: _____ Enacted ☐
Is the client in hospital? ☐ No ☐ Yes Hospital: _____ Date Admitted: _____/_____/_____

Please be aware ACAT cannot accept a Community Referral until after the client is discharged from hospital

Mr / Mrs / Miss / Ms

Surname: _____ **Given Name/s:** _____
(Please include second name)

DOB: ____/____/_____ **Age:** _____ **Sex:** **M** **F**

Marital Status: M / DF Wid Sin Div Sep Unk _____

Address: _____ **Suburb:** _____

Post Code: _____ **Phone No:** (H) _____ (Mobile) _____

Country of Birth: _____ **Aboriginal or Torres Strait Islander?** ☐ Yes ☐ No

Interpreter Required? ☐ No ☐ Yes **Language/s Preferred:** _____

Medicare No: _____ / _____ **Expiry Date:** _____ **DVA Card No/Type:** _____

Checked: ☐ Consent ☐ Name ☐ DOB ☐ Address

MAKE APPOINTMENT WITH: Client ☐ or Other ☐ _____
(Name / Number)

CONTACT PERSON: _____ Relationship: _____
Address: _____ Post Code: _____
Email: _____ Fax: _____
Phone: (H) _____ (W) _____ (Mob) _____

GENERAL PRACTITIONER: _____ Phone No: _____
Practice: _____ Health Summary Requested: ☐ Yes ☐ No

SOCIAL CIRCUMSTANCES: Lives Alone: ☐ Yes ☐ No If No: Lives with: _____
Has a Carer? ☐ No ☐ Yes Name: _____ Relationship: _____

SAFETY ISSUES/ALERTS: (e.g. dogs, weapons, aggression) _____

_____

PURPOSE OF ASSESSMENT:

Medical History (please tick/circle)

☐ Cancer Type _____

☐ Cardiac Conditions IHD MI Other _____

☐ Circulatory Disease Hyper / Hypotension Other _____

☐ Depression / Anxiety _____

☐ Dementia Type _____

☐ Diabetes Diet / Insulin Controlled / Oral Medication _____

☐ Gastrointestinal _____

☐ Mental Illness Specify _____

☐ Musculoskeletal OA OP Other _____

☐ Neurological Disease Stroke (…… year) ABI Other _____

☐ Renal Disease Specify _____

☐ Respiratory Disease Emphysema _____

☐ Sensory _____

☐ Other _____

Functional Profile:

Personal Hygiene (incl assist level) _____

Continence (incl aids) _____

Mobility/Falls (incl aids) _____

Social Interactions/Community Access _____

IADL _____

Medication Management _____

Cognitive Profile:

☐ Normal ☐ Short Term Loss ☐ Long Term Loss ☐ Hallucinations

☐ Aware of time and place ☐ Confusion ☐ Paranoia ☐ _____

Challenging Behaviours:

☐ Resistive Verbal / Physical ☐ Wandering ☐ Disruptive ☐ Intrusive ☐ _____

Services In Situ (please specify service provider)

☐ Allied Health _____ ☐ Domiciliary Nursing _____

☐ Respite Day/Home _____ ☐ Home Care _____

☐ Hygiene Assistance _____ ☐ Meals on Wheels _____

☐ Package _____ ☐ Palliative Care Program _____

Any Referrals to support services in situ: _____

ACAT Office Use Only:

Screening indicates may be eligible: ☐ **Residential Placement** ☐ **High** ☐ **Low** ☐ **Residential Respite**

☐ **CACPs Package** ☐ **EACH Package** ☐ **DEACH Package**

Intake Officer: _____ Referral Checked: ☐ Yes ☐ No

Clinical Contact: ☐ Yes ☐ No Date of Contact: _____/_____/_____

Priority Level:

☐ Cat 1 - 48 hours ☐ Cat 2 - 3-14 days ☐ Cat 3 - Over 14 days

Clinical Notes/Reason for priority level: