

**QUEENSLAND ONGOING
NEEDS IDENTIFICATION
CORE ONI
Contact Information**

Facility: _____

(Affix client identification label here)

URN: _____

Family Name: _____

Given Names: _____

Date of Birth: _____ Sex: M F

If question is irrelevant or information not known, write Not Applicable or N/A

Title _____ Other _____
 Family Name: _____
 Given Names: _____
 Preferred Name/s: _____
 Sex Male Female
 Date of birth dd/mm/yyyy _____
 Not estimated Estimated

Who the agency can contact if necessary
 (eg, case manager, next of kin, carer, guardian, enduring power of attorney, friend, emergency contact)

Person 1 Name

 Contact details _____ (number & street)
 _____ (locality & postcode)
 Phone: _____
 Relationship to client _____

Contact details
 Usual Address _____ (number & street)
 _____ (locality & postcode)
 Contact Address (if different from usual address) _____ (number & street)
 _____ (locality & postcode)
 Contact phone number's _____

Person 2 Name

 Contact details _____ (number & street)
 _____ (locality & postcode)
 Phone: _____
 Relationship to client _____

	Tick preferred number:	Can leave message? Y or N
Home:		
Work:		
Mobile:		
Fax:.....		
Email address:.....		

General Practitioner (if no GP, write N/A)
 Name _____
 Contact details _____ (number & street)
 _____ (locality & postcode)
 Phone: _____
 Fax: _____
 Email: _____

Comments (incl. directions or other relevant contact issues)

Details of person completing this page

Name _____ Designation _____ Agency _____
 Sign _____ Date _____ Contact Number _____

If information needs updating, indicate below and record updated information on a new Contact Information form.

This information has been updated? Sign: _____
 Name: _____ Date: _____

DO NOT WRITE IN THIS BINDING MARGIN

QLD ONI - CORE ONI

**QUEENSLAND ONGOING
NEEDS IDENTIFICATION
CORE ONI
Service Entry Data Set**

Facility: _____

(Affix client identification label here)

URN: _____

Family Name: _____

Given Names: _____

Date of Birth: _____ Sex: M F

If question is irrelevant or information not known, record 99

Source of Referral

- Record: (1) Self.
- (2) Family, significant other, friend.
- (3) GP/medical practitioner – community based.
- (4) Aged Care Assessment Team.
- (5) Community nursing or health service
- (6) Hospital
- (7) Psychiatric/mental health service or facility.
- (8) Extended care/rehabilitation facility
- (9) Palliative care facility/hospice
- (10) Residential aged care facility.
- (11) Aboriginal health service
- (12) Other medical/health service
- (13) Other community-based service.
- (14) Law enforcement agency
- (15) Other: _____
- (99) Not stated / inadequately described.

Preferred language, (if not spoken English) including sign language, and any required communication devices or special interpreter needs.

Government Pensioner/Benefit Status

- Record: (1) Aged Pension
- (2) Veterans' Affairs Pension (complete DVA Card Status below)
- (3) Disability Support Pension
- (4) Carer Payment (pension)
- (5) Unemployment related benefits
- (6) Other government pension or benefit. If so, specify: _____
- (7) No government pension or benefit

Pension/Benefit Card Number

If not self-referred, has client given consent for referral?
Y N

Medicare Number

Source of Referral Contact Details (if not GP)

Health Care Card Number

Country of Birth

- Record: (1) Australia (2) Other
- If other, specify _____

DVA Card Status

- Record:
- (1) Yes - gold card
- (2) Yes - white card
- (3) Other DVA card: _____
- (4) No DVA card

Indigenous status:

- (1) *Aboriginal* but not Torres Strait Islander origin
- (2) *Torres Strait Islander* but not Aboriginal origin
- (3) *Both* Aboriginal and Torres Strait Islander origin
- (4) *Neither* Aboriginal nor Torres Strait Islander origin
- (9) Not stated or inadequately described

DVA Card Number

Do you ever need help to communicate

- (to understand or be understood by others):
- (1) No
- (2) Yes, sometimes
- (3) Yes, always

Insurance Status

- Tick all that apply:
- (1) None
- (2) Private health insurance – basic cover only
- (3) Private health insurance – including auxiliary cover for private dental and allied health services
- (4) Motor vehicle accident insurance
- (5) Workers' compensation
- (6) Other 3rd party
- (7) Ambulance fund
- (99) Irrelevant or information not known

Main Language Spoken at Home

- Record: (1) English (2) Other
- If other, specify: _____

Health Insurer Name and Card Number

Interpreter Required

- Record:
- (1) Interpreter not needed
- (2) Interpreter needed

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Sign _____ Date _____ Contact Number _____

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DO NOT WRITE IN THIS BINDING MARGIN

QLD ONI - CORE ONI

DO NOT WRITE IN THIS BINDING MARGIN

QLD ONI - CORE ONI

<p>QUEENSLAND ONGOING NEEDS IDENTIFICATION</p> <p>CORE ONI</p> <p>Reason(s) the Consumer is Seeking Services</p> <p>Facility: _____</p>	<p>(Affix client identification label here)</p> <p>URN: _____</p> <p>Family Name: _____</p> <p>Given Names: _____</p> <p>Date of Birth: _____ Sex: M F</p>
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If question is irrelevant or information not known, write Not Applicable or N/A

Alerts (including any relevant comments on risk or urgency)

ONI Priority Rating: Record rating here if relevant profiles have been completed to indicate relative priority for service

	Description of problem or issue as identified by the consumer or referring agency	Action/s required
1		
2		
3		
4		

Description of other issues as identified by the consumer or in the Ongoing Needs Identification process

1	
2	
3	
4	
5	

<p>ACTION REQUIRED: Code</p> <p>(1) Service provision – see Action Plan</p> <p>(2) Specialist assessment</p> <p>(3) Comprehensive assessment</p> <p>(4) Nil: Consumer ineligible for service</p>	<p>(5) Nil: Referred elsewhere</p> <p>(6) Nil: Advice/information provided. No further action required</p> <p>(7) Nil: Consumer declines further referral or service</p>	<p>(8) Nil: Consumer issue resolved. No further action required</p> <p>(9) Nil: Service not available.</p> <p>(10) Nil: Requested service not accessible (eg, due to long waiting time, inaccessible location)</p>
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Current services

Record services used in the last three months or on a recurring basis. If more than 8 services used, append an additional page

Service	Record contact details or other information as appropriate

Consider all health, community and support services, including (but not limited to) formal domestic and personal care arrangements, Alternate Therapists, Aged Care, Alcohol and drug, Community health, Counselling, Dental care, Disability, Emergency accommodation, Family planning, Home care, Hospital inpatient, Hospital outpatient, Hospital emergency, Maternal and child health, Medical (GP), Medical (specialist), Men's health, Mental health, Palliative care, Rehabilitation, Residential Aged Care, Respite care, Self help groups, Sexual health, Women's health and Youth services.

Details of person completing this page

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Sign _____ Date _____ Contact Number _____

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Name: _____ Date: _____

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**QUEENSLAND ONGOING
NEEDS IDENTIFICATION
CORE ONI
Action Plan**

Facility: _____

(Affix client identification label here)

URN: _____

Family Name: _____

Given Names: _____

Date of Birth: _____ Sex: M F

If question is irrelevant or information not known, write Not Applicable or N/A

Is this person HACC eligible? Yes No Don't know

Is this person eligible for disability services? Yes No Don't know

Is this person eligible for other support services (eg, DVA, NRCP)? Yes No *If yes, specify:* _____

Functional Profile is completed and attached? Yes No **Alternately, summarise Functional Profile below:**

Item 1	Item 2	Item 3	Item 4	Item 5	Item 6	Item 7	Item 8	Item 9	Total score

After completing the relevant optional profiles, finalise the Action Plan below.

Action Plan

Taking into account the reason/s that the consumer is seeking services and any other issues you and the consumer have subsequently identified, summarise the action required. If more than 7 actions are required, append an additional sheet.

To be referred to (use codes below):

Agency/health professional	For	Consumer Consent	Referral Method	Transport Method	Feedback required	Date	Review Date

Agency/health professional: if you will be continuing to see the client, include yourself in the list of agencies/professionals for referral

For: Record purpose of referral

Consumer Consent: Record (1) Yes, consumer consents to referral and to sharing of information (2) Yes, consumer consents to referral but not to sharing of information (3) No, consumer has not consented to this referral

Referral method: Record (1) this form faxed to agency (2) letter (copy on file) (3) electronic (4) verbal request – face to face or phone call (5) other (incl. refer to self)

Transport Method: Record (1) Staff travel – service is delivered in home (2) Staff travel – client too unwell to travel (3) Staff travel – client has no transport (4) Client travel – own car (5) client travel – family/friends (6) Client travel – public transport or taxi

(7) Client travel – walk (8) Community transport (9) Ambulance (10) Hitchhike (11) None

Feedback required: Record (1) to initial referral agency (2) to GP (3) to agency completing ONI (4) to carer/guardian (5) other

Date: Record date referral actually made. If no referral actually made, leave blank

Review Date: Record date when action should be reviewed. If no need for review, leave blank

I have discussed the proposed referral/s and use/s of their personal information with the consumer/carer. I am satisfied that the consumer/carer understands the proposed uses and disclosures of the information that has been provided, and has provided their informed consent to these. Y N

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DO NOT WRITE IN THIS BINDING MARGIN

QLD ONI - CORE ONI

**QUEENSLAND ONGOING
NEEDS IDENTIFICATION
FUNCTIONAL PROFILE**

Facility: _____

(Affix client identification label here)

URN: _____

Family Name: _____

Given Names: _____

Date of Birth: _____ Sex: M F

If consumer does not answer, record 9

Questions to ask the consumer (or the person who represents the consumer).

I would like to ask you about some of the activities of daily living, things that we all need to do as part of our daily lives. I would like to know if you can do these activities without any help at all, if you need some help to do them or if you can't do them at all. These questions refer to how you are managing at the moment.

Item	Question	Score	Record score
1	Can you do housework...		
	Without help (can clean floors etc)?	3	
	With some help (can do light housework but need help with heavy housework?)	2	
Or are you completely unable to do housework?	1		
2	Can you get to places out of walking distance...		
	Without help (can drive your own car, or travel alone on buses or taxis)?	3	
	With some help (need someone to help you or go with you when travelling)?	2	
Or are you completely unable to travel unless emergency arrangements are made for a specialised vehicle like an ambulance?	1		
3	Can you go out shopping for groceries or clothes (assuming you have transportation)...		
	Without help (taking care of all shopping needs yourself)?	3	
	With some help (need someone to go with you on all shopping trips)?	2	
Or are you completely unable to do any shopping?	1		
4	Can you take your own medicine...		
	Without help (in the right doses at the right time)?	3	
	With some help (able to take medication if someone prepares it for you and/or reminds you to take it)?	2	
Or are you completely unable to take your own medicines)?	1		
5	Can you handle your own money...		
	Without help (write cheques, pay bills etc)?	3	
	With some help (manage day-to-day buying but need help with managing your chequebook and paying your bills)?	2	
Or are you completely unable to handle money?	1		

Do not ask the following 2 questions if the client scored 2 on all of the above 5 items (ie, can do all 5 activities without help). Instead, for clients who scored 2 on all of the above items, record a 9 on each of the following 2 items to indicate that you did not ask the question.

6	Can you walk...		
	Without help (except for a cane or similar)?	3	
	With some help from a person?	2	
Or are you completely unable to walk?	1		
7	Can you take a bath or shower...		
	Without help?	3	
	With some help (eg, need help getting into or out of the bath)?	2	
Or are you completely unable to bathe yourself?	1		

NOTES:

- If unanswered, score 9.
- Rate what the person is **currently capable** of doing rather than what they actually do. In assessing capability, take into account not only physical function but also cognition (such as problems caused by dementia or an intellectual disability) and behaviour (such as unpredictable challenging behaviour). Consumers able to complete a task with verbal prompting should not be rated as independent (and therefore should be rated as a 2).
- In rating an item that is irrelevant (for example, the person has no shops in the vicinity or does not use any medications), rate based on what the person would be capable of doing if the item was actually relevant to their situation.
- Item 6 (walking). Clients who are in a wheelchair should be rated as (2) if they are independent including corners etc or (1) if they are not wheelchair independent.

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Details of person completing this page Summarise issues and arising action on pages 3 and 4 of the core ONI.

Name _____ Designation _____ Agency _____

Sign _____ Date _____ Contact Number _____

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This information has been updated? Sign: _____

Name: _____ Date: _____

DO NOT WRITE IN THIS BINDING MARGIN

QLD ONI - FUNCTIONAL PROFILE

**QUEENSLAND ONGOING
NEEDS IDENTIFICATION
FUNCTIONAL PROFILE**

(Affix client identification label here)

URN: _____

Family Name: _____

Given Names: _____

Date of Birth: _____ Sex: M F

Facility: _____

If consumer does not answer, record 9

Questions for you to complete

Complete the following based on all information available to you – your judgement based on interviewing or observing the client, information contained in a referral letter, consumer notes or information provided by a proxy respondent, such as a friend, relative carer or referring agency.

Note that the consumer should not be directly asked to answer these questions

Item	Question	Record score
8	Does the person have any memory problems or get confused?	
	No – score 2	
	Yes – score 1	
9	Does the person have behavioural problems for example, aggression, wandering or agitation?	
	No – score 2	
	Yes – score 1	
Total score:		

Recommended functional assessments based on this Functional Profile *(tick all that are recommended)*

Domestic
Look solely at items 1 to 5. Count the number of these items that scored 3 (ie, count the number of activities that the person can do without help). Refer for a domestic functional assessment if the person can do less than 3 activities without assistance – ie, the count is 2 or less (a count of 0, 1 or 2).

Self-care
Refer for a self-care functional assessment if the consumer SCORED LESS THAN 3 on either Item 6 (mobility) or Item 7 (bathing).

Cognition
Refer for a cognitive assessment if:

- the consumer scored LESS THAN 3 on either Item 4 (medicine) or Item 5 (financial management) AND you have determined that the consumer has no physical disabilities or problems with English literacy that may account for the consumer not being independent on these items OR
- the consumer scored 1 on Item 8.

Behaviour
Refer for a behavioural assessment if:

- the consumer scored LESS THAN 3 on either Item 4 (medicine) or Item 5 (financial management) AND you have determined that the consumer has no physical disabilities or problems with English literacy that may account for the consumer not being independent on these items OR
- the consumer scored 1 on Item 9.

Aids and equipment currently used *(tick all that apply)*

- | | |
|--|--|
| <input type="checkbox"/> Self-care Aids | <input type="checkbox"/> Medical Care Aids |
| <input type="checkbox"/> Support and Mobility Aids | <input type="checkbox"/> Car Modifications |
| <input type="checkbox"/> Communication Aids | <input type="checkbox"/> Aids for Reading |
| <input type="checkbox"/> Other (list): | |

Comments

Details of person completing this page *Summarise issues and arising action on pages 3 and 4 of the core ONI.*

Name _____ Designation _____ Agency _____

Sign _____ Date _____ Contact Number _____

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This information has been updated? Sign: _____

Name: _____ Date: _____

DO NOT WRITE IN THIS BINDING MARGIN

QLD ONI - FUNCTIONAL PROFILE

**QUEENSLAND ONGOING
NEEDS IDENTIFICATION
LIVING ARRANGEMENTS PROFILE**

Facility: _____

(Affix client identification label here)

URN: _____

Family Name: _____

Given Names: _____

Date of Birth: _____ Sex: M F

If question is irrelevant or information not known, record 99

Living Arrangements
Record: (1) Lives alone (2) Lives with family
(3) Lives with others

Comments on living arrangements, including family arrangements (consider issues such as stability of arrangements, number of people in household etc)

Financial and legal profile
Mental Health Act status
Record (1) Involuntary (2) Forensic Order (3) N/A

Decision-making responsibility
Record: (1) Self (2) Significant Informal Assistance
(3) Enduring Power of Attorney (4) Advance Health Directive (5) Formal Administrator or Guardian

Is the person capable of making their own decisions?

Yes No Not Sure

If 'not sure' or 'no', consider the need for assistance, need for cognitive assessment and the implications for consent.

Accommodation Setting
Record: (1) Private residence – owned/purchasing
(2) Private residence – private rental (3) Private residence – public rental (4) Independent living unit within a retirement village (5) Boarding house/private hotel (6) Short term crisis, emergency or transitional accommodation facility (7) Supported accommodation or supported living facility (8) Institutional setting (9) Public place/temporary shelter (10) Private residence rented from Aboriginal Community (11) Other

Comments on accommodation

Financial decisions
Record: (1) Self (2) Significant Informal Assistance
(3) Enduring Power of Attorney (4) Parent or Guardian (5) Formal Financial Administrator or Manager

Cost of living decisions
Because of limited income, has the consumer during the last month made any trade-offs among purchasing any of the following: prescribed medications, necessary medical care, adequate food, necessary home care, necessary transport?

Yes No Not Sure

If yes, discuss issues with consumer and consider need for counselling (eg, financial, gambling, drug or alcohol) and need for material support.

Comments on legal and financial issues. Consider all legal issues including current legal orders (eg, AVO)

Consider accommodation status above if home modifications are required

Employment Status
Record: (1) Employed/self employed (2) Sheltered
(3) Child/Student (4) Home duties (5) Unemployed (6) Retired for age (7) Retired for disability (8) CDEP (9) Other

Comments on employment

Details of person completing this page *Summarise issues and arising action on pages 3 and 4 of the core ONI.*

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Sign _____ Date _____ Contact Number _____

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DO NOT WRITE IN THIS BINDING MARGIN

**QUEENSLAND ONGOING
NEEDS IDENTIFICATION
CARER PROFILE**

Facility: _____

(Affix client identification label here)

URN: _____

Family Name: _____

Given Names: _____

Date of Birth: _____ Sex: M F

If question is irrelevant or information not known, record 99

Carer Availability

- (1) Has a Carer
- (2) Has no Carer
- (3) Not Applicable – no Carer required
- (98) Not Applicable – paid Carer

CARER DETAILS

Family name:

Given names:

Date of birth:

Not estimated Estimated

Usual address:

(number & street)

(locality & postcode)

Country of birth:

Sex:
(1) Male
(2) Female

Language spoken at home:
 English (1201)
 Other (specify):

Indigenous status:
(1) Aboriginal but not Torres Strait Islander origin
(2) Torres Strait Islander but not Aboriginal origin
(3) Both Aboriginal and Torres Strait Islander origin
(4) Neither Aboriginal nor Torres Strait Islander origin
(9) Not stated or inadequately described

Carer for more than one person:
(1) Yes
(2) No

Need for a Carer:

- (1) The consumer cannot be left on their own at any time (whether by day or night)
- (2) The consumer can only be left on their own for some, but not all, of the time (whether by day or night)
- (3) Nil, no Carer required

Carer Residency Status

- (1) Yes – Co-resident Carer
- (2) No – Non-resident Carer
- (3) Not Applicable – the consumer has no Carer
- (98) Not Applicable – paid Carer

Relationship of Carer to Care Recipient

- (1) Spouse/partner
- (2) Parent
- (3) Son or daughter
- (4) Son-in-law or Daughter-in-law
- (5) Other relative
- (6) Friend/neighbour
- (98) Not Applicable – paid Carer

Carer Support

Does Carer have someone to help them?
 Yes No Not sure No Carer

Does Carer receive a Carer Payment or Allowance?
 Yes No Not sure No Carer

Has Carer been given information about available support services?
 Yes No Not sure No Carer

Does Carer need practical training in lifting, managing medicine or other tasks?
 Yes No Not sure No Carer

If 'not sure' or 'no' to any of the above, consider the need to provide information and for assistance to arrange required support services.

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QLD ONI - CARER PROFILE

**QUEENSLAND ONGOING
NEEDS IDENTIFICATION
CARER PROFILE**

Facility: _____

(Affix client identification label here)

URN: _____

Family Name: _____

Given Names: _____

Date of Birth: _____ Sex: M F

If question is irrelevant or information not known, record 99

- Current threats to carer arrangements** Tick all that apply
- (1) Carer – emotional stress & strain
 - (2) Carer – acute physical exhaustion/ illness
 - (3) Carer – slow physical health deterioration
 - (4) Carer – factors unrelated to care situation
 - (5) Consumer – increasing needs
 - (6) Consumer – other factors

Comments (if applicable):

Carer Issue/s	Consider completing on Carer:
If carer requires HACC or HACC-like services	Functional and Living Arrangements Profiles
Health – consider the carer’s overall health, age-related problems, disabilities, use of medicines	Health Conditions Profile
Psychosocial – consider the carer’s mental health and emotional wellbeing, personal and social supports, family and personal relationships	Psychosocial Profile
Functional status and activities of daily living – consider the carer’s overall health, age related problems, disabilities	Functional Profile
Health behaviours – consider the carer’s living arrangements, housing, work, financial, legal	Health Behaviours Profile
Determinants of health - consider the carer’s living arrangements, housing, work, financial, legal	Living Arrangements Profile

Are carer arrangements sustainable without additional services or support?
Consider carer role, client needs, and current threats to carer arrangements when scoring

(1) No, arrangements have already broken down

(2) No, carer arrangements likely to break down within weeks

(3) No, carer arrangements likely to break down within months

(4) Yes, carer arrangements are sustainable without additional support

(5) Don't know

Comments

Details of person completing this page *Summarise issues and arising action on pages 3 and 4 of the core ONI.*

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Sign _____ Date _____ Contact Number _____

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Name: _____ Date: _____

DO NOT WRITE IN THIS BINDING MARGIN

QLD ONI - CARER PROFILE

**QUEENSLAND ONGOING
NEEDS IDENTIFICATION
HEALTH CONDITIONS PROFILE**

Facility: _____

(Affix client identification label here)

URN: _____

Family Name: _____

Given Names: _____

Date of Birth: _____ Sex: M F

If question is irrelevant or information not known, write Not Applicable or N/A

Overall health N/A
In general, would you say your health is?
 Excellent Very Good Good Fair Poor
How much bodily pain have you had during the past 4 weeks?
 None Very Mild Moderate Severe Very Severe
How much did your health interfere with your normal activities (outside and/or inside the home) during the past 4 weeks?
 Not at all Slightly Moderately Quite a bit

Vision and Hearing
Is your eyesight for reading (with your glasses)?
 Excellent Good Fair Poor N/A
Is your long distance eyesight (with your glasses)?
 Excellent Good Fair Poor N/A
Hearing is your hearing (with your hearing aid)?
 Excellent Good Fair Poor N/A

Oral health N/A
Problems with teeth, gums, dentures, including eligibility to access services?
 Yes No
Comments:

If yes, consider referral, Functional Profile and Health Behaviours Profile

Speech/Swallowing N/A
Problems with speech &/or swallowing?
 Yes No
Comments:

If yes, consider referral, Functional Profile and Health Behaviours Profile

Falls N/A
Have you had a fall inside/outside the home in the past 6 months?
 Yes No
If yes, record number of falls: _____
Comments:

Consider both Functional Profile and need for referral if the consumer has any problems with vision, hearing or falls.

Feet N/A
Problems with one or both feet? Yes No
Comments:

Vaccinations: N/A

	Influenza	Pneumococcus	Tetanus	Other:
Date:				

Driving N/A
Drives a motor vehicle? Yes No
Fit to drive? (Refer AustRoads Guidelines) Yes No
Comments:

Continence N/A
How frequently is urine leakage experienced?
 (0) Never
 (1) Less than once a month
 (2) 1 to several times a month
 (3) 1 to several times a week
 (4) Every day and / or night
What amount of urine is lost each time?
 (1) A few drops
 (2) A little
 (3) More
Record score of frequency: X Record points for amount = Severity Index
How frequently is faecal incontinence experienced (leak, have accidents or lose control with stool)?
 (0) Never
 (1) Rarely (less than once in the past four weeks)
 (2) Sometimes (less than once a week, but more than once in the past four weeks)
 (3) Often or Usually (less than once a day but more than once a week)
 (4) Always (more than once a day)
Comments:

Height and weight N/A
Weight: _____kg Height: _____m
BMI: _____

BP/Pulses N/A
Systolic BP: _____mm/Hg Diastolic BP: _____mm/Hg
Pulse Regular Irregular Pulse rate: _____
Consider check for postural hypotension? Yes No

Details of person completing this page *Summarise issues and arising action on pages 3 and 4 of the core ONI.*
Name _____ Designation _____ Agency _____
Sign _____ Date _____ Contact Number _____
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Name: _____ Date: _____

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QLD ONI - HEALTH CONDITIONS PROFILE

**QUEENSLAND ONGOING
NEEDS IDENTIFICATION
HEALTH CONDITIONS PROFILE**

Facility: _____

(Affix client identification label here)

URN: _____

Family Name: _____

Given Names: _____

Date of Birth: _____ Sex: M F

If question is irrelevant or information not known, write Not Applicable or N/A

Health conditions as reported by consumer or carer

Include all relevant issues eg, allergies, acute medical conditions, disabilities, continence, dental developmental)

Condition	Condition
1	5
2	6
3	7
4	8

Medical diagnoses confirmed by doctor

Include all issues eg, allergies, acute medical conditions, disabilities, continence, dental, developmental

Diagnosis	Diagnosis
1	5
2	6
3	7
4	8

Current Medicines

Include prescriptions, over-the-counter, bush medicine and alternate products (including other people's medicine)

1	7	13
2	8	14
3	9	15
4	10	16
5	11	17
6	12	18

Cooperation with treatment								Score	
Does this person generally look after and take her or his own prescribed medication without reminding?	0	Reliable with medication	1	Slightly unreliable	2	Moderately unreliable	3	Extremely unreliable	
Is this person willing to take medication when prescribed by a doctor?	0	Always	1	Usually	2	Rarely	3	Never	
Does this person cooperate with health services (eg, doctors and/or other health workers)?	0	Always	1	Usually	2	Rarely	3	Never	
Webster Pack or similar used for medicine?	Yes	No							
Review of medications recommended?	Yes	No							

Comments

Details of person completing this page *Summarise issues and arising action on pages 3 and 4 of the core ONI.*

Name _____ Designation _____ Agency _____

Sign _____ Date _____ Contact Number _____

If information needs updating, indicate below and record updated information on a new Contact Information form.

This information has been updated? Sign: _____

Name: _____ Date: _____

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QLD ONI - HEALTH CONDITIONS PROFILE

**QUEENSLAND ONGOING
NEEDS IDENTIFICATION
HEALTH BEHAVIOURS PROFILE**

Facility: _____

(Affix client identification label here)

URN: _____

Family Name: _____

Given Names: _____

Date of Birth: _____ Sex: M F

If question is irrelevant or information not known, write Not Applicable or N/A

Regular health checks

Yes No

If yes, record last date or year _____

If yes, record health screens in last 2 years (eg, pap smear, breast, prostate)

Malnutrition

Use the total score below to decide whether action is required.

	Yes	No	Score
1. Have you lost weight recently without trying? <i>Notes: 'recently' means last 6 months. If consumer unsure, ask if clothes are looser etc</i>	Yes	No	0*
	No	Unsure	0 2
<i>*If yes, complete 1a</i>			
1a. If yes, how much weight have you lost? (in kilograms)	1-5	6-10	11-15
	1	2	3
		>15	4
		Unsure	2

Weight

Underweight

Average

Overweight

Consider referral to dietitian/specialist/comprehensive service if significantly under or over weight

Smoking

- Never smoked
- Has quit smoking
- Currently smokes

If quit, record when
Consider referral if currently a smoker

2. Have you been eating poorly because of decreased appetite? <i>Note: decreased appetite means eating less than ¼ of usual food intake. 'eating poorly' may be due to problems with swallowing and chewing. If so, score yes.</i>	Yes	No	1	0
Total score				

Total score of 2 or more: consumer at risk of malnutrition. Consider referral to GP or dietitian.

Physical activity

Would you do at least 30 minutes of moderate physical activity (such as walking or yard work or any other type of exercise) on most days of the week?

Yes No

Consider referral if 'no'.

Physical fitness

During the past 4 weeks... what was the hardest physical activity you could do for at least 2 minutes?

- Very heavy (for example) run, fast pace; carry a heavy load upstairs or uphill (25 lbs., 10 kg)
- Heavy (eg) jog, slow pace; climb stairs or a hill at moderate pace
- Moderate (eg) walk, medium pace; carry a heavy load level ground (25 lbs., 10kg)
- Light (eg) walk, medium pace; carry a light load on level ground (10 lbs., 5 kg)
- Very light (eg) walk, slow pace; wash dishes

Consider both Functional Profile and need for referral if response is 'light' or 'very light'.

Alcohol

How often do you have a drink containing alcohol?

- Never *If never, proceed to next section*
- Less than monthly
- Monthly
- Once a week
- 2-4 times per week
- 5+ per week

How many standard drinks do you have on a typical day when you are drinking?

(Refer to ONI manual for definition of a standard drink)

How often do you have more than 6 standard drinks on one occasion?

- Never
- Monthly
- Once a week
- 2-4 times per week
- 5+ per week

Consider referral if alcohol consumption is an issue

Hydration

Do you regularly drink at least 8 cups of fluid every day?

(A) Yes (B) No

If answer to question above is (B), have you recently decreased your fluid intake?

(A) No (B) Yes

If answer is (B) to either of the above, consider referral to GP or health professional.

Comments, including other relevant issues (eg, other substance use, safe sex practices, men's health issues) and opportunities for health promotion

Details of person completing this page

Summarise issues and arising action on pages 3 and 4 of the core ONI.

Name _____ Designation _____ Agency _____

Sign _____ Date _____ Contact Number _____

If information needs updating, indicate below and record updated information on a new Contact Information form.

This information has been updated? Sign: _____

Name: _____ Date: _____

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**QUEENSLAND ONGOING
NEEDS IDENTIFICATION
ONI PRIORITY RATING TOOL**

(Affix client identification label here)

URN: _____

Family Name: _____

Given Names: _____

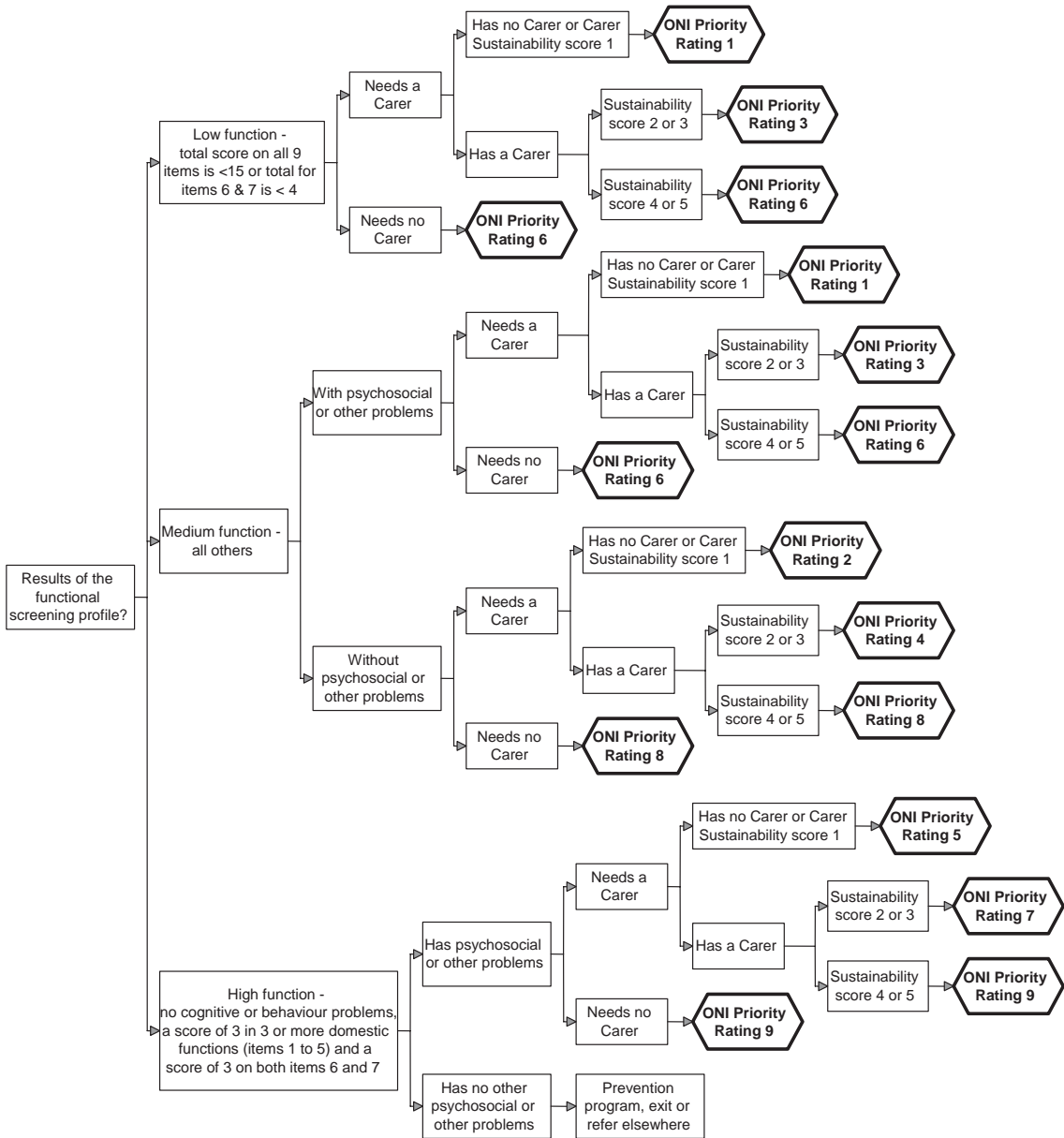
Date of Birth: _____ Sex: M F

Facility: _____

ONI Priority Rating: To be completed following screening process to indicate relative priority for service

Option 1: Decision Making Flow Chart

An alternate way to identify the ONI Priority Rating is shown on page 2 of this profile. Complete either page 1 or page 2, not both. Work through this tool, using either the flow chart below or the matrix over the page. If using the flow chart, circle the relevant box at each step. Definitions of psychosocial and other problems are on page 2. See ONI Manual for more detail. Record the ONI Priority Category on the Core ONI, page 3.



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QLD ONI - ONI PRIORITY RATING TOOL

v2.05 - 01/2007
www.health.qld.gov.au/hacc

Details of person completing this page

Summarise issues and arising action on pages 3 and 4 of the core ONI.

Name _____ Designation _____ Agency _____

Sign _____ Date _____ Contact Number _____

If information needs updating, indicate below and record updated information on a new Contact Information form.

This information has been updated? Sign: _____

Name: _____ Date: _____

**QUEENSLAND ONGOING
NEEDS IDENTIFICATION
ONI PRIORITY RATING TOOL**

Facility: _____

(Affix client identification label here)

URN: _____

Family Name: _____

Given Names: _____

Date of Birth: _____ Sex: M F

ONI priority rating: To be completed following screening process to indicate relative priority for service

Option 2: Decision Making Matrix

This is an alternate way to identify the ONI Priority Rating shown in more detail on page 1 on this profile. Complete either page 1 or page 2, not both.

Definitions of psychosocial and other problems are below. See ONI Manual for more detail. Record the ONI Priority Category on the Core ONI, page 3

RISK (all rated in Carer Profile)	NEED			
	Low function Total score on all 9 items is <15 or total for items 6 & 7 is < 4	Medium function (not Low or High Function)		High function but psychosocial or other problems. High function – no cognitive or behaviour problems, a score of 3 on 3 or more domestic functions (items 1 to 5) and a score of 3 on both items 6 and 7
		with significant psychosocial or other problems (see below)	with no significant psychosocial or other problems (see below)	
Needs a carer but has no carer or carer arrangements have already broken down Need for Carer Status item – score 1 or 2. Carer Availability item – score 2 OR Carer Sustainability item – score 1	1	1	2	5
Carer arrangements exist but are unsustainable without additional resources (likely to break down in weeks to months) Need for Carer Status item – score 1 or 2. Carer Sustainability item – score 2 or 3	3	3	4	7
Carer arrangements suitable and sustainable Carer Sustainability item – score 4 or 5 OR Carer not required Need for Carer Status item – score 3 or 4	6	6	8	9

Psychosocial problems (all in Psychosocial Profile)
K10 score of 30 or more **AND/OR**
No personal and social support **AND/OR**
Significant family and personal relationships problems (score of 4 on both items)

Other problems
Consumer mistrusts health and community service providers (Psychosocial Profile) **AND**
Does not cooperate with health services (Health Conditions Profile) **OR**
Significant behavioural problems (Functional Profile) **OR**
Significant cognitive problems (diagnosis of dementia in Health Conditions Profile or cognitive problems (Functional Profile) **OR**
Decision-making problems (Living Arrangements Profile)

Note: If the relevant profile is not completed, rate that the person has no problems. For example, if no Carer Profile is completed, rate the consumer as having no carer risks.

Details of person completing this page *Summarise issues and arising action on pages 3 and 4 of the core ONI.*

Name _____ Designation _____ Agency _____

Sign _____ Date _____ Contact Number _____

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Name: _____ Date: _____

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QLD ONI - ONI PRIORITY RATING TOOL

**QUEENSLAND ONGOING
NEEDS IDENTIFICATION**

HACC MDS SUPPLEMENTARY ITEMS

Facility: _____

(Affix client identification label here)

URN: _____

Family Name: _____

Given Names: _____

Date of Birth: _____ Sex: M F

If question is irrelevant or information not known, record 99

Complete only if the Living Arrangements and/or Carer Profile not completed. Otherwise, leave blank.

Living arrangements

(1) Lives alone

(2) Lives with family

(3) Lives with others

CARER DETAILS

Family name:

Accommodation Setting

(1) Private residence – owned/purchasing

(2) Private residence – private rental

(3) Private residence – public rental

(4) Independent living unit within a retirement village

(5) Boarding house/private hotel

(6) Short term crisis, emergency or transitional accommodation facility

(7) Supported accommodation or supported living facility

(8) Institutional setting

(9) Public place/temporary shelter

(10) Private residence rented from Aboriginal Community

(11) Other

Given names:

Date of birth:

Not estimated Estimated

Carer availability

(1) Has a carer

(2) Has no Carer

(3) Not Applicable – no Carer required

(98) Not Applicable – paid Carer

Usual address:

_____ (number & street)

_____ (locality & postcode)

Carer Residency Status

(1) Yes – Co-resident Carer

(2) No – Non-resident Carer

(3) Not Applicable – the consumer has no Carer

(98) Not Applicable – paid Carer

Country of birth:

Relationship of Carer to Care Recipient

(1) Spouse/partner

(2) Parent

(3) Son or daughter

(4) Son-in-law or Daughter-in-law

(5) Other relative

(6) Friend/neighbour

Sex:

(1) Male

(2) Female

Language spoken at home:

English (1201)

Other (specify): _____

Comments

Indigenous status:

(1) *Aboriginal* but not Torres Strait Islander origin

(2) *Torres Strait Islander* but not Aboriginal origin

(3) *Both* Aboriginal and Torres Strait Islander origin

(4) *Neither* Aboriginal nor Torres Strait Islander origin

(9) Not stated or inadequately described

Carer for more than one person:

(1) Yes

(2) No

Details of person completing this page *Summarise issues and arising action on pages 3 and 4 of the core ONI.*

Name _____ Designation _____ Agency _____

Sign _____ Date _____ Contact Number _____

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Name: _____ Date: _____

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QLD ONI - HACC MDS SUPPLEMENTARY ITEMS