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**Instructions**

This plan is developed by the occupational therapist in collaboration with the person or their representative, plus other treating therapists, in preparation for discharge from hospital. The aim of the plan is to ensure a smooth transition from hospital to the community and support optimal independence/recovery outcomes.

The assessment considers the allied health, other therapy and support services required for a transition period. Refer to the [Attendant care provider guidelines](https://www.tac.vic.gov.au/providers/working-with-tac-clients/guidelines/provider-guidelines/attendant-care-provider-guideline). If home services are required, please discuss the need for a Home Services Assessment and Plan with the TAC. A review of support and other services will occur within 3 months after discharge.

# Section 1

## TAC client details

|  |  |
| --- | --- |
| First name |   |

|  |  |
| --- | --- |
| Last name |   |

|  |  |  |  |
| --- | --- | --- | --- |
| TAC claim number |   | Date of accident |  / /  |

|  |  |
| --- | --- |
| Date of birth |  / /  |

|  |  |
| --- | --- |
| Street name and number |   |

|  |  |  |  |
| --- | --- | --- | --- |
| Suburb/Town |   | Post code |   |

|  |  |
| --- | --- |
| Client phone number |   |

|  |  |
| --- | --- |
| Client email address |   |

|  |  |
| --- | --- |
| Key contact if not client |   |

|  |  |
| --- | --- |
| Key contact phone number |   |

|  |  |
| --- | --- |
| Relationship of key contact |   |

(e.g. parent, partner, guardian)

Accident injuries

|  |
| --- |
|   |

Known pre-existing medical conditions

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| --- |
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| --- | --- | --- |
| Discharge summary attached |   |  |

# Section 2

## Discharge destination

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| --- | --- |
| Where is the person being discharged? |   |

**If private accommodation**, what is the proposed address?

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| --- | --- | --- |
| **If residential aged care**, has an ACAS assessment been completed? |   |  |

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| --- | --- | --- |
| Will this be ongoing or transitional accommodation? |   |  |

Provide additional information about the discharge location.
**If transitional accommodation**, provide estimated length of stay and details of transitional plan.

(e.g. Is the person aiming to transition to independent living? Is the person awaiting completion of home modifications?)

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# Section 3

## Goals

Outline the goals you have identified with the person to achieve through the provision of the support services.
For example, does the person have future goals for community participation? What supports would be required?
Include employment, education, leisure and recreation.

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# Section 4

## Current capabilities

### Physical, sensory, mobility and transfers

Include indoor/outdoor mobility, upper and lower limb function, balance, strength/endurance and any required splinting or assistive technology (e.g. hoists, powered wheelchairs).

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### Cognitive and behavioural

Include memory, insight and distractibility.

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### Psychological and emotional

Note any comments from the person, their carers or other providers about relationships and managing life stressors.

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### Communication, hearing, vision, tactile and swallowing

Note any difficulties, support or special requirements.

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### Continence

Note any difficulties, support or special requirements.

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### Recommended funded support needs

Consider physical, cognitive, behavioral and/or other barriers to the person’s occupational performance and participation when describing how they manage tasks in these key life areas:

* Personal care (e.g. showering, feeding, grooming, toileting)
* Domestic activities, including need for domestic services (e.g. laundry, cleaning, meal prep)
* Community access, including work, study and recreation (e.g. shopping, attending gym, banking)
* Therapy support (e.g. home exercise program)
* Organisation and time management

| ActivityInclude:* Personal care
* Domestic activities
* Community access
* Therapy support
* Organisation and time management
 | Type of assistance required(e.g. physical assistance, verbal prompting/supervision, one or two person support, assistive technology required) | Are there Independence goals related to this activity? | Recommended funded hours |
| --- | --- | --- | --- |
|   |   |   |   |
|   |   |   |   |
|   |   |   |   |
|   |   |   |   |
|   |   |   |   |
| Total hours |   |

### Other relevant considerations

Provide information on any factors that may impact how personal supports are delivered and by whom. For example, are there cultural considerations or religious beliefs? Does the person require support with financial management and decision making? If so, who supports them and are there any conflicts of interest/advocates or concerns to note?

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| --- | --- | --- |
| Are you recommending any level of overnight support? |   |  |

Provide details of the person’s identified overnight care needs. Outline the type and frequency of specific tasks required overnight and who completes these tasks, e.g. paid support (external worker or family) or gratuitous support.

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| --- | --- | --- |
| Can the person’s overnight care needs be met with a personal alarm/monitoring service? |   |  |

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| --- | --- | --- |
| **If yes**, does the person also require a daily welfare check conducted by the monitoring service?  |   |  |

Provide the clinical reasoning to support your recommendation to engage an on-call monitoring service and detail the frequency and type of support required.

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| --- | --- | --- |
| Are you recommending sleepovers (inactive overnight support)? |   |  |

For example, paid support (external worker or family)

Provide clinical justification for sleepovers and why the person’s support need cannot be met by using the overnight on-call monitoring service. Provide details of alternatives to 1:1 sleepovers that you have considered (e.g. gratuitous care, equipment, etc.). Please note that information regarding the different types of overnight support is available on the
TAC website.

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| --- | --- | --- |
| Number of sleepover nights required per week |   |  |

|  |  |  |
| --- | --- | --- |
| Active hours per night |   |  |

|  |  |  |
| --- | --- | --- |
| Inactive hours per night |   |  |

# Section 5

## Clinical justification

Does the person have any gratuitous or informal supports in place to assist? Please outline any discussion and recommendations relating to informal support that can or will be provided.

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Provide clinical justification for the funded support hours recommended in the weekly timetable and section 3,
with reference to the attendant care clinical reasoning pathway related to the following areas for which a person requires assistance:

* Personal care
* Domestic activities
* Community participation, including work, study and recreation
* Therapy support
* Overnight support needs
* Organisation and time management

Consider current capabilities and anticipated improvement/recovery; family and other supports in place; any risk management required for the person’s safety in the post-discharge environment. Include a proposed timeframe for review of supports. For example, is 3 months a reasonable timeframe for review?

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# Section 6

## Proposed weekly support plan

Indicate where all TAC funded and unfunded informal supports are required during the week: personal care (PC), community access (CA), therapy support (TS), domestic services (DS), community group programs (CGP), etc.

If further details are required for complex needs, please attach an additional weekly planner breakdown.

|  | Morning | Afternoon | Evening | Total hours per support type per day |
| --- | --- | --- | --- | --- |
| **Example** |  7-9 am PC (bowel care, showering, dressing): 2 hours  9-10 am TS (stretching): 1 hour11am-12pm CGP: 1 hour  | 1-3 pm DS: 2 hours 3-4 pm CA (transport, shopping): 1 hour | 6-7 pm PC (dinner preparation): 1 hour | PC: 3 hoursCA: 1 hour TS: 1 hourDS: 2 hoursCGP: 1 hour |
| **Monday** |   |   |   |   |
| **Tuesday** |   |   |   |   |
| **Wednesday** |   |   |   |   |
| **Thursday** |   |   |   |   |
| **Friday** |   |   |   |   |
| **Saturday** |   |   |   |   |
| **Sunday** |   |   |   |   |
|  | Total funded hours |   |

# Section 7

## Assistive technology/equipment

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| --- | --- | --- |
| Is any assistive technology being provided or hired for discharge? |   |  |

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| --- | --- | --- |
| Is detailed information about assistive technology needs provided in the discharge summary?  |   |  |

**If no**, provide relevant information to inform future assistive technology assessment.

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# Section 8

## Allied health/therapy services required post-discharge

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| --- | --- |
| What services are required post-discharge? |   |

Complete the details below only if the person is to be linked to community-based therapists.

| Discipline | Has referral been made? | Contact name | Practice location | Phone number |
| --- | --- | --- | --- | --- |
|   |   |   |   |   |
|   |   |   |   |   |
|   |   |   |   |   |
|   |   |   |   |   |

# Section 9

## Recommendations for further assessment

Include assistive technology, home modifications and vehicle modifications, driving assessment, home services review.

|  |  |  |
| --- | --- | --- |
| Do you recommend further assessments or interventions for this person?  |   |  |

**If yes**, please complete the following table.

| Proposed assessment or intervention | Provider type |
| --- | --- |
|   |   |
|   |   |
|   |   |
|   |   |

# Section 10

## Verification and signing

|  |  |
| --- | --- |
| I certify that I have assessed this person and that the information and opinions contained in this document are, to the best of my professional knowledge, true and correct. |   |
|  |

|  |  |
| --- | --- |
| I confirm that I have discussed this Transition Allied Health and Support Plan with the person or their representative and have their consent to supply the TAC with the information collected. |   |
|  |

|  |  |
| --- | --- |
| I confirm that I have discussed the timeframe for review of these recommendations with the person or their representative. |   |
|  |

|  |  |
| --- | --- |
| I confirm that I have involved the Early Support Coordinator (ESC) in the preparation of this plan. |   |

|  |  |
| --- | --- |
| Provider name, address, email and phone number(Type details or insert image of practice stamp) |  |

|  |  |
| --- | --- |
| SWEP credentialing level |   |

|  |  |
| --- | --- |
| Days/hours available |   |

|  |  |
| --- | --- |
| SignatureInsert image (jpg/png) of signature.(Or print, sign and scan the form) |  |



|  |  |
| --- | --- |
| Date |  / /  |

****

**Submitting this form**

Email your completed form to your TAC claims manager or to info@tac.vic.gov.au with the client’s TAC claim number in the subject line. Please also attach any supporting documentation.

**Privacy**

The TAC will retain the information provided and may use or disclose it to make further inquiries to assist in the ongoing management of the claim or any claim for common law damages. The TAC may also be required by law
to disclose this information. Without this information, the TAC may be unable to determine entitlements or assess whether the treatment is reasonable and may not be able to approve further benefits and treatment. If you require further information about our privacy policy, please call the TAC on 1300 654 329 or visit our website at [www.tac.vic.gov.au](http://www.tac.vic.gov.au)