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**Instructions**

Complete this form when the TAC requests a review of a person’s capabilities and the supports required to enhance the person’s participation in their personal, home and community activities. The assessment can include physical, cognitive and emotional functioning as well as the environmental aspects and assistive technology that enhance participation.

Refer to the OT Referral for Assessment for background information and for specific areas of function to be addressed during the assessment.

# 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)

|  |  |
| --- | --- |
| Date of previous *Review of Capabilities* |  / /  |

Reason for referral

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Risk advice for site visit. Precautions or concerns, if known.

(Provider to carry out own home visit assessment of risks)

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# Section 2

## Contributors to the review

Comment on the person’s ability to engage and any strategies used to engage the person if there are
communication barriers.

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Other people contributing to the review, and information used, in the *Review of Capabilities.*

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| --- | --- | --- | --- |
| Name | Relationship to person (e.g. family member, friend, support worker, TAC support coordinator or claims officer) | Contact telephone number | Means of information provision(e.g. report, verbal contact, present during the assessment, date of contact ) |
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# Section 3

## Pre-accident function

What was the person’s pre-accident functionin regard to personal, domestic and community activities?Please consider the person’s usual duties, frequency of completion, how the tasks were managed.

(e.g. help from family members, friends/neighbours)

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# Section 4

## report on funded program

What is the person’s level of satisfaction with their current TAC funded program? Include any strategies used to support the person to communicate if there are communication barriers. Note if they are achieving goals for participation in desired activities, plus a summary of the key life areas/activities they would like to focus on in the future.

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# Section 5

## Current funded supports

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| Other services | Funding source(if relevant)  | Support persone.g. family member, friend, independent support worker. | Current hours per week and frequency of funded services |
| Personal care |   |   |   |
| Therapy support |   |   |   |
| Community access |   |   |   |
| Inactive sleepovers |   |   |   |
| Active sleepovers |   |   |   |
| Allied health assistant |   |   |   |
| Community based recreation/leisure supports (e.g. neighbourhood house) |   |   |   |
| Community group programs |   |   |   |
| Childcare |   |   |   |
| Taxi services  |   |   |   |
| Home services |   |   |   |
| Gardening |   |   |   |
| Residential care |   |   |   |
| On-call services: Day and/or night |   |   |   |
| Other: (Please specify) |   |   |   |

Is there any gratuitous support provided, who provides this and on what basis?

(e.g. daily, weekly)

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# Section 6

## Current status and performance

Provide a summary of person’s current capabilities. Include relevant details in the following sections, as required, noting how capabilities relate to injuries from the transport accident.

### Injuries and health

Note any updated information regarding TAC-accepted medical conditions, pre-accident injuries or illnesses and
non-TAC related conditions**.**

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### Home, living and social situation

Outline the relationship with other people living at the residence, any recent changes and stability of current situation. Is the person satisfied in their current situation? Any anticipated changes?

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### Physical, sensory, mobility and transfers

Include indoor/outdoor mobility, upper and lower limb function, balance, strength/endurance and any splinting or assistive technology required.

(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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### Rest, sleep and hygiene

Note the person’s or carer’s report on sleep routine, hours of sleep and rest and any difficulties reported.

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### Cultural issues and preferences to be considered in assessment and in provision of services

Note any cultural considerations, religious beliefs and/or other factors that impact on decisions regarding management of supports.

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# Section 7

## Home environment summary

Please outline a summary of the person’s home environment in table below:

| Topic  | Comments | Insert photo(s) if applicable |
| --- | --- | --- |
| Details of pre-injury home (where relevant) |   |  |
| Current home type (e.g. single storey house) |   |  |
| Number of bedrooms |   |  |
| Number of bathrooms |   |  |
| Number of living areas |   |  |
| Type of flooring carpet/tiles |   |  |
| Access to home (external/internal, steps) |   |  |
| General presentation (e.g. garden, surrounds; outline size of lawn as relevant) |   |  |
| Does the person own standard and safe domestic/garden appliances and equipment? **If no**, how did they manage pre-injury?  |   |  |
| Additional comments regarding home environment (e.g. assistive technology, home modifications in place) |   |  |

# Section 8

## Assistive technology

Provide details of the person’s current assistive technology and any maintenance/repair requirements. List any items the person no longer requires. Do these items require retrieval by the TAC?

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# Section 9

## Assessment of capabilities and support needs

### Personal care

Note how the person manages grooming, bathing, dressing, toileting, eating and nutrition and medication.

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### Domestic tasks

Note how the person manages laundry, cleaning, meal prep, etc.

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### Community participation

Does the person have future goals for community participation? What supports would be required? Include employment, education, leisure and recreation.

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### Other relevant issues

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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### Recommended funded support needs

In the table below, identify the type of support and amount of time required for either maintenance or capacity-building activities related to the following areas for which a person requires assistance:

* 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) | Support providerPaid support (external worker or family)  | Is person’s status likely to change? | Current funded hours | Recommended funded hours |
|   |   |   |   |   |   |
|   |   |   |   |   |   |
|   |   |   |   |   |   |
|   |   |   |   |   |   |
|   |   |   |   |   |   |
| Total |   |   |

Additional comments and justification about support needs activities and responsibilities. For example, the capacity of attendant carer to overlap/combine duties.

(Comment on potential overlapping of tasks, such as the ability to make bed or tidy bathroom while person is toileting.)

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# SECTION 10

## Recommended home services plan

Summarise home services support separately to other funded supports.

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| --- | --- | --- | --- |
| Task | Type of required support  | Frequency and time required(hours per week) | Duration of services (review period) |
|   |   |   |   |
|   |   |   |   |
|   |   |   |   |
| Total hours |   |   |

# Section 11

## Overnight care and daily welfare check

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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) |  |
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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). 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/week |   | Active hours per night |   |

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

# Section 12

## Fire, emergency and safety management

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| Are there any factors you are aware of that impact on this person’s ability to respond appropriately in an emergency? |  |
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If relevant, please provide further details.

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| Would you recommend referral to Fire Risk Victoria for more detailed assessment and action plan based on your observations during this assessment? |  |
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If relevant, please add any further comments or observations made that may assist in moving forward.

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# Section 13

## Other relevant information and comments to support decisions and recommendations

Include specific discussions with other providers regarding the recommendations, such as concerns with how the care/support is being provided.

(e.g. conflict of interest, quality of care, opportunities to increase safeguarding on the program if family/friend is a paid carer)

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# SEction 14

## Proposed weekly support planner

Please indicate where TAC-funded supports are required during the week: personal care (PC), community access (CA), therapy support (TS), domestic services (DS) community group programs (CGP), etc.

|  | Morning | Afternoon | Evening | Total hours per support type per day |
| --- | --- | --- | --- | --- |
| **Example** | 7-9 am PC(bowel care, showering, dressing): 2 hours9-10 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 hours per week** |   |

# Section 15

## Recommendations for further assessment

Include assistive technology, home modifications and vehicle modifications.

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

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

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

# SECTION 16

## Summary and recommendations

Provide a summary of recommended funded support hours and a time frame for review.Include all funded support hours including attendant care, overnight support and funded home services and a timeframe for review. Summarise the person’s goals in regard to building their independence and how the relevant components of these TAC-funded services will support them to achieve these goals.

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# SECTION 17

## PROVIDER DETAILS

|  |  |
| --- | --- |
| 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** |  / /  |

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**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)