Austin Health

**Aged and Residential Care Services- Information and ACCESS service** Jan 07

**Community and Ambulatory Care Services Available**

| Description of Service | Target Population | Catchment | Documentation required |
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| **Aged Care Assessment Service (ACAS)** is a team who help older people and their carers work out what kind of care will best meet their needs when they're no longer able to manage themselves at home with out assistance. They provide information on suitable care options and can help arrange access and/or referral to appropriate community or residential care services.<br>The multi disciplinary team comprises of<br>• Nurses,<br>• Occupational Therapists,<br>• Speech Therapists,<br>• Social Workers<br>• Geriatricians | People **over the age of 65 years**<br><br>People **under the age of 65 years with an aged related condition**.<br><br>People **under the age of 65 years with other disabilities by negotiation with disability services.** | Heidelberg<br>Heidelberg Heights<br>Heidelberg West<br>Bellfield<br>Ivanhoe<br>Eaglemont<br>Viewbank<br>Rosanna<br>Macleod<br>Yallambie | **FROM GP's**<br>Standard GP letter including<br>• Reason for referral<br>• Medications<br><br>**FROM OTHERS**<br>**SCOTT components required**<br>• Consumer Information Form<br>• Summary & Referral Form<br>• Consumer Consent Form<br>• Health Conditions Profile - helpful but not required<br>• Living Arrangements Profile - helpful but not required.<br>Other documentation required -<br>Disability services support letter for under 65's with non-age related disabilities. |
| **ACAS Clinic** offers cognitive assessments and medical reviews for patients referred.<br>Services include:-<br>• Cognitive assessment for formal diagnosis of dementia and access to dementia specific medication<br>• Medication reviews<br>• Medical management/consultations.<br>• RITH (Rehab in the Home) reviews.<br>• CRC (Community Rehabilitation Centre) reviews | As Above | As above | **FROM GP's**<br>Standard GP letter including<br>• Reason for referral<br>• Medications<br><br>**FROM OTHERS** |
| The **Cognitive Dementia & Memory Service (CDAMS)** is a service that provides specialist diagnosis information & support for people who are affected by memory loss, confusion & thinking problems.<br>The service is made up of a multidisciplinary | Persons (& their carers/families) of **any age that may be experiencing memory & thinking changes**; and who may be seeking a formal diagnosis of their | As per ACAS<br><br>Outside these areas **will** be seen however; priority is given to clients in | **FROM GP's**<br>**GP's letter**, including current medications, medical history & any results of recent brain scans or other relevant tests. Blood tests should include U&E, Cr, FBE, TFT, LFT, B12, folate, RBS, VDRL, ESR, |

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| team that includes a Geriatrician, Neurologist, Counsellor, Community Nurse, Neuropsychologist, Occupational Therapist, Social Worker & Speech Pathologist. | condition and/or support for their condition. | the Banyule region. Those clients must also organise their own transport unless eligible for veterans transport | **FROM OTHERS**<br>**SCOTT components required:**<br>• Referral Cover Sheet<br>• Living Arrangements<br>• Consumer Information Form<br>• Health Profile<br>• Summary & Referral Form<br>• Consumer Consent Form |
| The **Community Rehabilitation Service** provides multidisciplinary outpatient rehabilitation to people recovering from an acute illness, orthopaedic surgery or general debility. Rehabilitation is also provided to those who require therapy input to increase their mobility or independence at home or in the community.<br>Physiotherapy & Occupational Therapy are provided in a group environment.<br>Speech Therapy, Podiatry & Social Work are all by individual appointments.<br>Hydrotherapy is also available. | People **over the age of 65 years** living in their own home or in an SRS or hostel<br>Clients from NH's are not eligible to attend a CRC<br>Exclusion criteria<br>Clients who:<br>• Are NOT medically stable<br>• Are unable to learn new tasks<br>• Are unable to participate in a group setting<br>• Have no rehab goals<br>Live outside of the catchment areas and are unable to provide their own transport | As per ACAS<br><br>Outside these areas **CAN** be seen however; priority is given to Austin Health clients. Those clients must also organise their own transport unless eligible for veterans transport. | **FROM GP's**<br>• Standard GP Letter<br>• Self-referrals to the CRC require an accompanying letter from the GP.<br><br>**FROM OTHERS**<br>**SCOTT components required**:<br>• Referral Cover Sheet<br>• Consumer Information Form<br>• Living Arrangements Profile<br>• Summary & Referral Form<br>• Functional Profile<br>• Consumer Consent Form<br>Health Conditions Profile |
| **HACC services** include:-<br>• Planned Activity Group operates twice weekly<br>• Home therapy program offers short – term Physiotherapy and Occupational therapy in the home.<br>• Upright and Active Program – 11 week course – operates from the CRC is a falls prevention program offered to | People over 65 or people with a disability. | People living in the Banyule area.<br><br>People living in the Banyule area. | |

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| **Community Link – Rapid Response Service**<br>Community Link provides a rapid response service for older people presenting to the Austin Hospital Emergency Department, Banyule, Darebin or Nillumbik Community Health Centres or Local General Practitioner (GP) to prevent Austin Health inpatient admission or presentation to the Emergency Department (ED) where appropriate.<br><br>Provides short term supportive home care during periods of acute illness or deterioration | People **over the age of 65 years**<br><br>People **under the age of 65 years with an aged related condition**. | Banyule<br>Nillumbik<br>Darebin<br>Manningham - (shared with Peter James Centre)<br><br>Whittlesea and Moreland both by negotiation. | **FROM GP's**<br>GP's letter should include:-<br>• Details of current problem,<br>• Current medical issues,<br>• Past medical history,<br>• Current medications<br>**Personal and demographic information about the client.**<br><br>**FROM OTHERS**<br>SCOTT is NOT mandatory at this stage, however may be in the future.<br>• Summary & Referral Form<br>• Consumer Consent & Information Form<br>• Health Conditions Profile &- Living Arrangements Profile (helpful to include) |
| **Continence**<br>A multidisciplinary service offered to clients with bladder or bowel dysfunction<br>• Domiciliary service<br>• Outpatient clinics<br>• Comprehensive assessment<br>• Specialised investigations<br>• Individual treatment and management plans.<br>• Pelvic floor exercises & bladder retraining<br>• Advice on available aids to manage incontinence<br>• In home assessments | Anyone from the age of 16+ can be seen by the service. Do not need to fit the HACC criteria. | As Per ACAS | **FROM GP's**<br>• GP letter including the following<br>• Full medical history and medications.<br>• MSU and Abdo X-ray results Demographic details/age<br>• Presenting problem<br>• Service required – domiciliary or clinic<br><br>**FROM OTHERS**<br>External referrers who use the SCOTT are acknowledged via SCOTT acknowledgement form. |
| The **Falls and Balance Clinic** aims to<br>• Identify the risk factors that cause falls<br>• Makes recommendations to help prevent future falls.<br>Includes assessments by a<br>• Geriatrician & physiotherapist<br>Clients may be referred onto other ongoing services (Eg PT, CRC, OT and/or podiatry. | Clients who -:<br>• Have had a fall causing injury<br>• Have had 2 or more falls in the past 12 months<br>• Have a balance problem or a fear of falling | As per ACAS | **FROM GP's**<br>Self or GP referrals to the Falls and Balance Clinic require: -<br>• An accompanying letter from the GP outlining the client's problems;<br>• Falls history<br>Any investigations/tests already completed.<br><br>**FROM OTHERS**<br>SCOTT is **NOT** required. |