# 

*Once completed please e-mail this form to:* [*requests.lifetimecare@icare.nsw.gov.au*](mailto:requests.lifetimecare@icare.nsw.gov.au) *(for lifetime care) or* [*requests.workers-care@icare.nsw.gov.au*](mailto:requests.workers-care@icare.nsw.gov.au) *(for workers care) and include the following in the subject header:*

*CNR [Person’s name and number] [Coordinator name]*

*An Attendant Care Service Request (ACSR) should also be submitted if requesting attendant care services.*

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **1.1 PERSON’S details** | | | | | | | | | | | |
| **Name** |  | | | | | **Participant No. or Claim No.** | | | |  | |
|  | | | | | | | | | | | |
| **Address** |  | | | | | | | | | | |
|  |  | | | | |  | | | | | |
| **Contact Name** |  | | | | | **Contact Ph** | |  | | | |
|  | | | | | | | | | | | |
| **Date of injury** |  | | | | | **Age** | |  | | | |
|  | | | | | | | | | | | |
| **Injury** | | **TBI** | **SCI** | | | | **Other** *(specify)* | | | | |
|  | | | | | | | | | | | |
| **CANS level\*** | |  | |  | | | | | | | |
|  | | | | | | | | | | | |
| **SCI level** | |  | | **ASIA score** | | |  | | | |  |
|  | | | | | | | | | | | |
| **Incomplete SCI Attendant Care Score\*\*** | | | | | **ULMS** | | | | **Ambulation** | | |

***\**** *Care and Needs Scale (CANS) must be completed for all adults with brain injury*

***\*\**** *The Incomplete Spinal Cord Injury Attendant Care Score must be completed for all people with an incomplete spinal cord injury*

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **1.2 CARE NEEDS REVIEWER** | | | | | | |
| **Name** | |  | | | | |
|  | | | | | | |
| **Qualification** |  | | | | | |
|  | | | | | | |
| **Organisation** |  | | | | | |
|  | | | | | | |
| **Work days/hrs** |  | | | **Ph** |  | |
|  | | | | | |
| **E-mail** | |  | | | | |
|  | | | | | |
|  | | |  | | | |
|  | | | | | |

**1.3 STATUS**

|  |  |
| --- | --- |
| **Interim** | **Date of end of interim participation period:** |
| **Lifetime** | |

*For interim status, services cannot extend beyond the interim participation period*

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **1.4 DATES** | | | | | |
|  | | | | | |
| **Date of this review** | |  | | | |
|  | |  |  | | |
| **Proposed dates of this care period** *(Max 16 weeks for initial program)* | | **From** | | **To** | **Number of weeks** |
|  |  | |  | | |
| **This review has been discussed with the care coordinator from the attendant care provider** | | **Yes** – name  **No** – reason | | | |
|  |  | |  | | |
| **Next review date** *(must be at least 4 weeks prior to expiration of proposed care period)* | |  | | | |
|  | | | | | |
|  | | | | | |

**2.1 SUMMARY OF PREVIOUS ATTENDANT CARE PROGRAM** *(include feedback from person, family and attendant care coordinator on any issues, successes, and utilisation of hours across the previous care period)*

**Not applicable** *(new program)*

|  |
| --- |
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|  |  |
| --- | --- |
| **2.2 Relevant reports***(if new, please attach)* | |
| **Details** | **Date** |
|  |  |
|  |  |

**3.0 WHAT IS THE PERSON’S CURRENT STATUS?** *(Only complete this section if the CNR is not being submitted with a My Plan)*

**3.1 Current injury related health and medical issues relevant to care**

|  |
| --- |
|  |

**3.2 Non-injury related health and medical issues relevant to care**

|  |
| --- |
|  |

**3.3 Pre-injury information relevant to care**

|  |
| --- |
|  |

**3.4 Living arrangements** *(for example, who else is living in the home, division of responsibilities, physical characteristics of the home)*

|  |
| --- |
|  |

**3.5 Care-related equipment**

|  |  |
| --- | --- |
| Hoist  Electric bed  Respiratory  Air mattress  Other *(specify)* | Communication devices  Exercise equipment  Powered wheelchair  Commode |
| **Is this equipment in place at the person’s home?**  **Yes**  **No**  **If no, when will it be in place?** | |

**4.0 FUNCTIONAL ASSESSMENT**

**4.1 Moving around**

*CNA04/07*

**Transfers:**

Assessed:

Level of assistance:

Type:

Reason:

Likely to change:

**Walking / using wheelchair:**

Assessed:

Level of assistance:

Type:

Reason:

Likely to change:

**Climbing stairs:**

Assessed:

Level of assistance:

Type:

Reason:

Likely to change:

**Bed mobility:**

Assessed:

Level of assistance:

Type:

Reason:

Likely to change:

**Running:**

Assessed:

Level of assistance:

Type:

Reason:

Likely to change:

**Other *(specify):***

Assessed:

Level of assistance:

Type:

Reason:

Likely to change:

**Reasons not assessed**

|  |
| --- |
|  |

**Functional changes since last care needs report**

|  |
| --- |
|  |

**Description of care tasks** *(include time required where relevant)*

**What alternatives to care have been considered?**

**What changes could be expected? And when?**

**4.2 Self-care activities**

**Eating:**

Assessed:

Level of assistance:

Type:

Reason:

Likely to change:

**Grooming:**

Assessed:

Level of assistance:

Type:

Reason:

Likely to change:

**Sleeping:**

Assessed:

Level of assistance:

Type:

Reason:

Likely to change:

**Bathing:**

Assessed:

Level of assistance:

Type:

Reason:

Likely to change:

**Dressing:**

Assessed:

Level of assistance:

Type:

Reason:

Likely to change:

**Toileting:**

Assessed:

Level of assistance:

Type:

Reason:

Likely to change:

**Managing medication:**

Assessed:

Level of assistance:

Type:

Reason:

Likely to change:

**Other *(specify):***

Assessed:

Level of assistance:

Type:

Reason:

Likely to change:

**Reasons not assessed**

|  |
| --- |
|  |

**Functional changes since last care needs report**

|  |
| --- |
|  |

**Description of care tasks***(include time required where relevant)*

**What alternatives to care have been considered?**

**What changes could be expected? And when?**

**4.3 Day to day routine and home responsibilities**

**Using telephone:**

Assessed:

Level of assistance:

Type:

Reason:

Likely to change:

**Shopping:**

Assessed:

Level of assistance:

Type:

Reason:

Likely to change:

**Food preparation:**

Assessed:

Level of assistance:

Type:

Reason:

Likely to change:

**Household cleaning:**

Assessed:

Level of assistance:

Type:

Reason:

Likely to change:

**Laundry:**

Assessed:

Level of assistance:

Type:

Reason:

Likely to change:

**Using transport:**

Assessed:

Level of assistance:

Type:

Reason:

Likely to change:

**Money management:**

Assessed:

Level of assistance:

Type:

Reason:

Likely to change:

**Using Computers / IT:**

Assessed:

Level of assistance:

Type:

Reason:

Likely to change:

**Gardening:**

Assessed:

Level of assistance:

Type:

Reason:

Likely to change:

**Other *(specify):***

Assessed:

Level of assistance:

Type:

Reason:

Likely to change:

**Reasons not assessed**

|  |
| --- |
|  |

**Functional changes since last care needs report**

|  |
| --- |
|  |

**Description of care tasks** *(include time required where relevant)*

**What alternatives to care have been considered?**

**What changes could be expected? And when?**

**4.4 Major areas of life and relationships**

O*ther activities the person is involved with and the assistance required.**Consider the person’s life roles, vocational activities, recreational activities, living in the community, family functioning, parenting skills, interpersonal skills, social interactions, etc*

**Reasons not assessed**

|  |
| --- |
|  |

**Functional changes since last care needs report**

|  |
| --- |
|  |

**Description of care tasks** *(include time required where relevant*)

**What alternatives to care have been considered?**

**What changes could be expected? And when?**

**5.0 ADDITIONAL CONSIDERATIONS**

**5.1 Are there any tasks that require support from more than one person?**

**Yes *(specify tasks below)*** **No**

|  |
| --- |
|  |

**Why is a second person required for these tasks?**

|  |
| --- |
|  |

**What alternatives have been considered?**

|  |
| --- |
|  |

**5.2 Is overnight care required?**

**Yes:  Active**

**Inactive**

**No**

**If yes, why is overnight care required?**

|  |
| --- |
|  |

**What alternatives to overnight care have been considered?**

|  |
| --- |
|  |

**5.3 Are there any tasks that require a registered nurse?**

**Yes: *(specify tasks below)***

**No**

|  |
| --- |
|  |

**5.4 Does the person have a care need relating to domestic services, garden or home maintenance?** *(The need should be described in section 4.3)***No**

**Yes: provide more information about the person’s home environment below** *(e.g. size/description of house, size of garden & lawn, any environmental risk factors, specific tasks to be completed & frequency). Include photos if relevant.*

|  |
| --- |
|  |

**6.0 SUMMARY OF OVERALL CARE NEEDS RELATED TO THE INJURY**

|  |  |
| --- | --- |
| **6.1 Total care needs related to the injury** | **Hours/frequency**  Per month or week |
| Total hours of care per week (excluding inactive sleepovers) |  |
| Second person (hours) |  |
| Inactive sleepover (number per week) |  |
| Registered nurse (hours) |  |
| Garden/home maintenance |  |

**6.2 Other factors**

|  |
| --- |
|  |

**7.0 SERVICE PROVIDER DECLARATION**

The person has been involved as much as possible in this review of care needs in collaboration with their family member, nominated person and attendant care coordinator where necessary. This report documents the person’s care needs related to the injury.

|  |  |  |  |
| --- | --- | --- | --- |
| **Name** |  | **Date** |  |

**Attendant Care Service Request (ACSR) attached?  Yes  No**