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**TOOLS**

**Client Record Baseline Audit** (Page 1 of 2)

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**Shared Transfer of Care**

**CLIENT DETAILS**

Client ID

Audit No.

Client DOB

Audit Date

Reason for entry to organisation

Relevant History

Pre-transfer residence

¨ Home ¨ Other, Please specify:

Post-transfer residence

¨ Home ¨ Subacute care (e.g. rehab) ¨ Aged/Residential Facility

¨ Other Please specify:

**TRANSFER PLANNING**

Entry Date

Length of stay (days)

Name of organisation where transfer planning commenced

Were the client’s goals identified on entry to organisation?

¨ Yes ¨ No

Transfer Risk Assessment Tool completed and documentation in medical record

¨ Yes ¨ No

Who was involved in creating the

transfer plan?

¨ Client

¨ Relative

¨ Carer

¨ Other

Was a Shared Information Record

commenced?

¨ Yes ¨ No Date commenced:

Were time lines discussed?

(i.e. Expected length of stay in the organisation)

¨ Yes ¨ No Date:

Discussed with Client

¨ Yes

¨ No

Discussed with Family/carer

¨ Yes

¨ No

Did the client have prior community services and have they been documented?

¨ Yes ¨ No

Comment

Were the above community services involved in planning the client’s transfer?

¨ Yes ¨ No

Comment

Other transfer information (i.e. from conversation with referrer or other)

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**Shared Transfer of Care**

**TRANSFER IMPLEMENTATION**

Were home and community services

advised of the client’s transfer?

¨ Yes

¨ No

¨ N/A

If yes, which services were referred and how was this communicated?

Name of Service

Date of Referral

Follow up phone call

Client aware

¨ Yes ¨ No

¨ Yes ¨ No

¨ Yes ¨ No

¨ Yes ¨ No

¨ Yes ¨ No

¨ Yes ¨ No

¨ Yes ¨ No

¨ Yes ¨ No

¨ Yes ¨ No

¨ Yes ¨ No

If there was more than one provider, were others notified of their involvement?

¨ Yes

¨ No

¨ Not documented

Was the client or family/carer given a

copy of the plan?

¨ Yes

¨ No

¨ N/A

How is this demonstrated?

¨ Signature on Plan

¨ Documented in Client Record

¨ Other

**WERE THE FOLLOWING CLIENT DETAILS DOCUMENTED?**

Appointments

Provider Name

¨ Yes

¨ No

¨ N/A

Contact Details

¨ Yes

¨ No

¨ N/A

Time/date

¨ Yes

¨ No

¨ N/A

Emergency Contact

¨ Yes

¨ No

Ongoing Care Information

¨ Yes

¨ No

Medication Information

¨ Yes

¨ No

Was the client’s general practice home

notified of: (tick all that apply)

¨ Yes

¨ No

¨ N/A

Were home and community services

advised of the client’s transfer?

¨ Entry to service

¨ Ongoing health care needs

¨ Final Transfer Plan

Comment

Was the client provided with a point

of contact after transfer?

¨ Yes

¨ No