Canberra Health Services

Justice Health Services

ADMISSION ASSESSMENT Form

Complete details or affix label

URN:

Family name:

Given names:

DOB: Sex:

Admission Date:	**Admission Time:**	**Admission Nurse Name:**

Assessment carried out in accordance with S.67 Corrections Management Act 2007 & S.161 Children and Young Persons Act 2008

Admission assessment unable to be performed due to: ☐ agitation ☐ aggression ☐ Intoxication ☐ Other

Provide details if other:

Client Details

DOB: Client's age at Admission: Alias: ☐ N/A

Sex: ☐ Male ☐ Female ☐ Intersex ☐ Transgender ☐ Other ☐ Not Supplied

Client's Community Contact Details:

Address:

Contact Number(s):

Next of Kin (NOK) Details:

Name:

Relationship: Contact Number(s):

Address:

Culture

Do you identify as Aboriginal or Torres Strait Islander? ☐ No ☐ Aboriginal ☐ both Aboriginal and Torres Strait Islander ☐ Torres Strait Islander

Would you like to be referred to an Aboriginal Liaison Officer? ☐ No ☐ Yes

Would you like to be referred to AMC Winnunga Health Care? ☐ No ☐ Yes

Country of birth: Preferred language: Interpreter needed? ☐ No ☐ Yes

ACTION: ☐ Ring for CHHS phone interpreter – [redacted] MHJHADS TIS Client Code [redacted]

ACTION: ☐ Refer to AMC Winnunga [redacted]

ACTION: ☐ Refer to an Aboriginal Liaison Officer [redacted]

Community Health Providers

Do you have a current GP? ☐ No ☐ Yes

Details (Name and Practice):

Do you see a specialist Doctor? ☐ No ☐ Yes

Details (Name, Practice and Specialty):

Do you see any other health care provider? ☐ No ☐ Yes

Details:

ACTION: ☐ Fax / email consented ROI(s) to Drs, OMT, Other:____

Food Intolerance / Avoidance

Do you have any food intolerance / avoidance? ☐ No ☐ Yes

If yes, what do you have food intolerance / avoidance to? Details:

ACTION: ☐ Advise Patient to discuss with ACTCS and ACTCS will submit ACTCS Special Diet Request form

Allergies & Adverse Reactions

Do you have any adverse reactions / allergies? ☐ No ☐ Yes

What is the substance type of adverse reaction / allergy? ☐ Medication ☐ Food ☐ Other

Name of substance(s):

Details of adverse reaction / allergy:

ACTION: ☐ Update Clinical Portal ☐ Update EMM

ACTION: ☐ Complete JHS Therapeutic Diet (MAJICeR) & email: [redacted]

DO NOT WRITE IN THIS BINDING MARGIN

DRAFT(0422)

Medical Observations

Blood Pressure = mmHg		Height in centimetres	
Pulse = bpm (beats / min)		Weight (kgs)	
Respiratory Rate = bpm (breaths / min)		BMI (weight / m²)	
Oxygen Saturation (SpO^2)		BGL (mmol / L)	
Temperature = Degrees Celsius (°C)		Breath Alcohol Concentration (BAC)	
Other: (e.g. GCS)		*If last drink < 36 hrs ago or currently intoxicated*	

ACTION: ☐Ensure there is a MAJICeR Entry – Patient Observations

Acute Health Conditions

Do you have any current injuries or conditions? ☐ No ☐ Yes

If yes, specify details:

Have you been hospitalised in the past 3 months? ☐ No ☐ Yes

If yes, specify (why, when were you admitted / discharged, where):

If yes, is there any requirement for follow up? Details:

CONSIDER - Acute Care – ED Referral & Discuss Clinical Handover with JHS MO

Current Medication & Therapeutic Devices

Are you currently taking any medications / have any devices? - If yes, please provide details ☐ No ☐ Yes

Medication / Device	Diagnosis / Reason	Dose	Route	Frequency	Duration	Last Taken
☐ CPAP machine						

OMT Medication	Prescriber and Dosing Location	Dose	Route	Frequency	Duration	Last Dose
☐ Buprenorphine LAI						
☐ Suboxone						
☐ Methadone						
☐ Other						

CONSIDER: ☐ Record in Clinical Portal EMM - Meds on Admission

ACTION: ☐ Fax / Email consented ROI(s) regarding medications

Tobacco Screening

1 Have you smoked tobacco in the last 30 days? ☐ No ☐ Yes (If yes, continue with tobacco screening)

2 Do you want to quit smoking? ☐ No ☐ Yes (If yes, continue with tobacco screening)

Nicotine Dependence

3 Do you smoke more than 10 cigarettes a day? ☐ No ☐ Yes

4 Do you smoke your first cigarette within 60 minutes of waking? ☐ No ☐ Yes

5 Do you have a history of withdrawal symptoms / cravings from quitting smoking? ☐ No ☐ Yes

CONSIDER: ☐Offer NRT – if program available

CONSIDER: ☐ MS Teams AOD Referral for smoking cessation

Alcohol and Other Drugs (AOD) Screen

Have you used alcohol or other drugs in the last four (4) weeks? ☐ No ☐ Yes

Have you injected any drugs / substances (i.e. heroin, steroids) In the last 3 months? ☐ No ☐ Yes

Substance Use

**** NB: All Pregnant women with any ADS Hx are AT RISK***
& Clinical Handover at Admission to JHS MO & AOD is mandatory*

Substance	Amount Used	Frequency	Route (IV, PO)	Last use?	Duration of use	History W-Withdrawal O-Overdose S-Seizures
Alcohol:(standard drinks)	No:					☐W ☐O ☐S
GHB:	☐ <4 mls ☐ >4mls ☐ >8mls					☐W ☐O ☐S

Alcohol Risk factors: *drink > 4 days / wk; Women > 6 std drinks / day; Men > 8 std drinks / day, last drink < 24hrs ago; drinks early morning; Hx of withdrawal / seizures*

ACTION: ☐AWS tool

ACTION: ☐ MS Teams AOD Referral

GHB Risk Factors: *> 6 times / day every day; > 4mls daily; polydrug use; last use was < 36 hours; Hx of withdrawal*

ACTION: ☐AWS and BWS tool

ACTION: ☐ MS Teams AOD Referral

Benzodiazepines (BZ):	***No: of Tabs & mgs***	***HIGH DOSES***	Frequency	Route (IV, PO)	Last use?	Duration of use	History
☐ Diazepam (Valium) (long)	tabs x mg	> 40mg / d					☐W ☐O ☐S
☐ Alprazolam (Xanax) (short)	tabs x mg	> 10mg / d					☐W ☐O ☐S
☐ Temazepam (Temaze)(short)	tabs x mg	> 30mg / d					☐W ☐O ☐S
☐ Oxazepam (Serepax) (short)	tabs x mg	> 120mg / d					☐W ☐O ☐S
☐ ***Other***	tabs x mg						☐W ☐O ☐S

BZ Risk Factors: *high doses, daily use, short acting BZ abrupt stop, Last use short acting ~ 6 hrs & long acting ~ 24hrs*

ACTION: ☐BWS Tool

ACTION: ☐MS Teams AOD Referral

Opioids (illicit):	Amount	Description	Frequency	Route (IV, PO)	Last use?	Duration of use	History
☐ Heroin		1 pt = 0.1g 1 cap = 0.1g or grams					☐W ☐O ☐S
☐ Buprenorphine		2 or 8mg films					☐W ☐O ☐S
☐ Methadone							☐W ☐O ☐S
☐ Morphine							☐W ☐O ☐S
☐ Codeine							☐W ☐O ☐S
☐ ***Other:***							☐W ☐O ☐S

Opioid Risk Factors: *use for > 6 months, daily Opioid Use, last use short acting ~ 6 - 24hrs ago, long acting ~ 24 - 96hrs ago*

ACTION: ☐OOWS Tool

ACTION: ☐MS Teams AOD Referral

STIMULANTS:	Amount	Description/ High Doses	Frequency	Route (IV, PO)	Last use?	Duration of use	History
☐ Methamphetamine (crystal, ice)		1 pt = 0.1g 8 ball = 3.5g					☐W ☐O ☐S
☐ Cocaine		1g 8 ball = 3.5g					☐W ☐O ☐S
☐ Amph. Type (Speed)							☐W ☐O ☐S
☐ **THC:** (Cannabis, pot, marijuana, weed)		Stick / Joint / Cone ~1g Q = 7g, 1/4 oz Half = 14g, 1/2oz 1 Oz = 28g					☐W ☐O ☐S
☐ **NON-PRESCRIBED:** (e.g. Seroquel, Lyrica)	tabs x mg	Seroquel 800mg Lyrica 600mg					☐W ☐O ☐S
☐ **OTHER:** (MDMA, psychedelics, inhalants)							☐W ☐O ☐S

ACTION: ☐ Other Withdrawal monitoring initiated

Name of Other Withdrawal Scale: .....

Mental Health, Suicide and Self Harm

JHS Custodial Mental Health (CMH) clinician present during Admission? ☐ No ☐ Yes

If CMH present, refer to CMH clinical notes.

If CMH **NOT** Present – Does the client have a known and current Mental Health diagnosis? ☐ No ☐ Yes

Diagnosis:

***NOTE: if CMH clinician NOT at Admission** - Client should be housed in CSU and advise ACTCS M15 Observations via **Primary Health Notification Form**. CMH will review within 24 hours of the person entering custody.*

Recommendations to ACTCS Regarding Visual M Observations

ACTCS M observations	***Frequency of observations***
☐ Nil	
☐ M1 – Serious condition / symptoms requiring immediate treatment	☐ every 15min for 24 hrs
☐ M2 – Condition requiring regular or ongoing treatment	☐ every 30min for 24 hrs
☐ M3 – Known or suspected condition / symptoms requiring assessment	☐ every 60 min for 24 hrs

ACTION: ☐ Complete Primary Health Notification Form for ALL NEW ADMISSIONS
☐ Copy to ACTCS and ☐ upload copy to MAJICeR

General Health Screen

Do you have any of the following chronic health conditions?

- *If relevant ask client - Date of last hospitalisation or ED attendance for condition*

☐ **N/A** ☐ **Cardiovascular conditions** (hypertension, chronic heart failure, rheumatic heart disease, cardiomyopathy, aneurism) if yes, details:

☐ **N/A** ☐ **Respiratory conditions** (asthma, COPD, sleep apnoea)
If yes, details:

☐ **N/A** ☐ **Diabetes** (Type 1, Type 2, Gestational)
If yes, details:

☐ **N/A** ☐ **Cancer** (current diagnosis, previous history)
If yes, details:

☐ **N/A** ☐ **Neurological conditions** (epilepsy, dementia, head trauma complications)
If yes, details:

☐ **N/A** ☐ **Musculoskeletal conditions** (conditions that involves muscles, bones, cartilage and / or joints)
If yes, details:

☐ **N/A** ☐ **Gastrointestinal conditions** (conditions that affect the digestive tract – e.g. stomach ulcers, throat, liver, bowel obstruction, gall bladder, pancreas If yes, details:

☐ **N/A** ☐ **Renal conditions** (any condition affecting the kidneys)
If yes, details:

☐ **N/A** ☐ **Dermatological** conditions (diagnosed chronic skin conditions such as psoriasis, eczema, dermatitis) If yes, details:

☐ **N/A** ☐ **Any other** chronic condition / concern not mentioned above (thyroid conditions, optometry, audiology, chronic pain, observed conditions). If yes, details:

☐ **N/A** ☐ **Physical or other impairment** conditions associated with a disability (e.g. blindness, amputation, learning delay)
If yes, details (including NDIS plan):

☐ **N/A** ☐ Any **Surgical history?**
If yes, details:

☐ **N/A** ☐ **Significant family medical history** (cancer, diabetes, cardiovascular disease)
If yes, details:

If aged over 50 years - When was your last **Bowel Cancer Screen** done?
Details:

☐ **History of Blood Borne Virus diagnosis** ☐ Hepatitis B ☐ Hepatitis C ☐ HIV ☐ Unsure ☐ Denies
When was your last BBV screen?

ACTION: ☐ MS Teams POP Health Referral - severe or unstable conditions
☐ Patient to submit Health Request - stable conditions

Sexual Health Screen

The following questions are sensitive in nature. ***'The reason I am asking the following questions, is to offer you any support, screening and medication treatment you may require.'***

In the last 3 months have you had any risky sexual contacts? ☐ No ☐ Yes

Have you had sex in the past seven (7) days? ☐ No ☐ Yes

Was this sexual interaction with everyone's consent? ☐ No ☐ Yes

If No, with the client's consent, the Nurse will inform the JHS MO & plan further care e.g. CFM

Was this sexual interaction with: ☐ Male ☐ Female ☐ Other

If Male to Male (MSM) sex, was a condom used? ☐ N/A ☐ No ☐ Yes

If Female to Male sex identified, were condoms or other contraception used? ☐ No ☐ Yes

ACTION: ☐ If non-consensual sex, Clinical Handover to JHS MO & Clinical Forensic Medicine (CFM) both via TCH switch
ACTION: ☐ If MSM risk = Clinical Handover to JHS MO for PEP
ACTION: ☐ If Pregnancy Risk - Clinical Handover to JHS MO for Emergency Contraception

Women's Health Screen

☐ **N/A client male**

Do you think you could be pregnant? ☐ Did not want to disclose ☐ No ☐ Yes
What was the date of the start of your last menstrual period?

Offer urine pregnancy test: ☐ Accepted ☐ Declined Result: ☐ Neg ☐ **POS**
Date: Time: Clinician's name: If declined, give reason:

Are you experiencing any abnormal vaginal bleeding? ☐ No ☐ Yes
Give details:

Have you had any previous pregnancies? ☐ No ☐ Yes
Have you had any gynaecological conditions? ☐ No ☐ Yes
If Yes provide details:

When was your **last cervical screening test** (CST or previous Pap smear)?
(CST for ALL women aged 25 to 74 – Due 2 years after last Pap smear or 5 years after last CST, unless abnormal)

Test type (please circle): Pap smear / CST Date test attended:

If aged over 50 years - When was your **last mammogram?**

Date of mammogram: Facility where mammogram was attended:

ACTION: ☐ Clinical Handover to JHS MO of all Pregnant Women
☐ MS Teams POP Health Referral - Pregnant Women & Women's' Health Issues

Additional Information

General Assessment - *Overall Physical, Emotional & Behavioural State*

SUMMARY of CLINICAL ISSUES for Clinical Handover

Clinical Handover Checklist	Yes	N/A
Notify JHS Medical Officer on-site / on-call with new admission Clinical Issues	☐	☐
Action immediate concerns as per proposed clinical plan by JHS MO (medications / monitoring)	☐	☐
Provide Verbal clinical handover to JHS team including items to be followed-up	☐	☐
Ensure ***MAJICeR*** Clinical Handover to JHS team including items to be followed-up is entered in ***MAJICeR*** Clinical Notes & Management Plan	☐	☐

CLINICAL HANDOVER

JHS Medical Officer's Name:

Time contacted (24-hour time): ☐ Clinic MO - Mon to Fri 0830 to 1700 ☐ ON CALL MO - After hours

Details (Medical Advice / proposed clinical plan / care management / clinical pathway):

Admission Nurse

Print Name: Designation: Signature: Date:

DRAFT(0422)

Canberra Health Services Justice Health Services **RECEPTION ASSESSMENT Form**	**Complete details or affix label** URN: Family name: Given names: DOB: Sex:

Reception Date:	**Reception Time:**
Assessment carried out in accordance with S.67 Corrections Management Act 2007 & S.161 Children and Young Persons Act 2008	
Falls assessment unable to be performed due to ☐ agitation ☐ aggression ☐ Intoxication ☐ Other	
State circumstances:	

Falls Risk	
Is the client aged over 65 years or 55 for Aboriginal and Torres Strait Islander clients	☐ No ☐ Yes
Has the client had a fall in the last 12 months?	☐ No ☐ Yes
Clinically, do you consider the client at risk of falling? ☐ No ☐ Yes	☐ No ☐ Yes
If yes to any of these screening questions, complete FRAT	

2. Falls Risk Assessment[1] **Standard 10**

☐ Assessment completed Date:_____ Time (24hrs): _____ Initials _____

Modified Stratify[1] Falls Tool Document admission assessments here. Document reassessments in Care Plan			**Score**
1.	Fall: current admission	☐ Patient had fall/s during current admission	3
2.	Fall: within 12 months	☐ Patient had fall/s in the last 12 months (from history)	1
3.	Cognition	☐ Patient is either confused, agitated, lacks insight or is impulsive	1
4.	Mobility	☐ Patient requires supervision or assistance with mobilising	1
5.	Impaired Balance	☐ Patient has impaired balance and/or hemiplegia	1
6.	Age	☐ Patient is 80 years old or older	1
7.	Toileting	☐ Patient is needing frequent toileting	1
8.	Vision	☐ Patient is visually impaired to the extent that everyday function is affected	1
9.	Drug/Alcohol	☐ Patient presented with drug/alcohol related problems	1
A score of 3 or more is considered 'HIGH RISK'. Use the Care Plan to choose appropriate interventions and management		**Risk Score**	

Falls Risk Actions	
Development and review of care plan for those at risk (ie. request shower chair, mobility aid, referral to physio)	☐ Complete (if not completed document on Electronic Clinical Record (ECR) why)
PHNF updated with falls risk and mitigation strategies (ie. no top bunk, lower-level floor, minimal clutter in cell	☐ Complete (if not completed document on ECR why)
Custodial Health team will review falls risk again within 14 days of client identified as being a falls risk request admin add this on ACTPAS	☐ Complete (if not completed document on ECR why)
Document on clinical handover sheet the client is at risk of falls	☐ Complete (if not completed document on ECR why)
Provide education to the client to mitigate risk (wearing of shoes, avoiding clutter in cell)	☐ Complete (if not completed document on ECR why)

Reception Nurse			
Print Name	Designation	Signature	Date