# **AT-HM prescription example**

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| --- | --- | --- | --- |
| **Client details** | | | |
| Full name |  | DOB |  |
| Address |  | | |
| Phone |  | Alt phone |  |
| **Prescriber details** | | | |
| Name |  | | |
| Profession and provider no if applicable |  | Phone |  |
| Email |  | | |
| Address |  | | |
| Date of assessment |  | Date of report |  |

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| --- |
| **Assessment summary** |
| xx |

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| --- |
| **Prescriber plan and wrap arounds** |
| xx |

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| --- | --- |
| **Prescriber signature** | **Date** |
| xx | xx |

## **AT-HM prescriber assessment**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Who was present at the assessment?** | | | | |
| xx | | | | |
| **Relevant client characteristics including medical history/disabilities** | | | | |
| xx | | | | |
| Height (cm): |  | | Weight (kgs): |  |
|  | | | | |
| Current social situation | |  | | |
| Current or previous formal services/allied health input | | * Currently approved for Support at Home classification x * AT tier * HM tier * Other | | |
| Past and current interests and activities | |  | | | |
| **Sensory** | | | | |
| xx | | | | |

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| --- |
| **Cognitive** |
| xx |

|  |
| --- |
| **Communication** |
| xx |

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| --- |
| **Pressure care** |
| xx |

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| --- |
| **Mobility and transfers including falls history** |
| xx |

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| --- |
| **Self-care** |
| xx |

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| **Instrumental activities of daily living** |
| xx |

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| --- |
| **Home environment and access - external** |
| xx |

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| --- |
| **Home environment and access - internal** |
| xx |