AT-HM prescription example

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	

Assessment summary
xx

Prescriber plan and wrap arounds
xx

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			

Cognitive
xx

Communication
xx

Pressure care
xx

Mobility and transfers including falls history
xx

Self-care
xx

Instrumental activities of daily living

xx

Home environment and access – external

xx

Home environment and access – internal

xx