# Outreach

Service Activity Report

## Eye and Ear Surgical Support Service

Report to be completed for **each visiting health professional** for **each location** after **each visit.**

| **Visit details** | | | |
|---|---|---|---|
| **Payee** | | | |
| **Health profession** | | | |
| **Health professional's name** | | | |
| **If employed by WA Health, was this professional backfilled?** ☐ Yes ☐ No | | | |
| **Was Medicare Benefits Schedule (MBS) billed for this service?** ☐ Yes ☐ No | | | |
| **# of clinical sessions* conducted** **1 session = 3.5-4 hours* | | | |
| **Location procedure delivered** | | **Procedure date** | |
| **# of new patients** | | **Planned # of patients** | |
| **# of patients** | | **Planned # of carers** | |
| **# of carers** | | **Reasons that patients or carers Did Not Attend (DNA)** | |
| **# of Aboriginal or Torres Strait Islander patients seen** | | **# of eye procedures**<br>**# of ear procedures** | |
| **Type of procedures performed** | | | |
| **Total number of Aboriginal or Torres Strait Islander patients that received surgery within the clinically recommended timeframes** | | | |
| **Home location/s of patients** | | | |

Continued overleaf

| Professional support (after the procedure) | Upskilling (pre/post procedure) |
|---|---|
| **If you are funded** (according to your organisation's Payment Schedule) to provide **professional support** to local health professionals after your visit, to assist continuity of care to patients, please list below:<br>Number of hours conducted _____<br>☐case discussions<br>☐telephone support<br>☐other _____ | **If you were funded** (according to your organisation's Payment Schedule) to conduct formal **upskilling activities** of a theoretical or clinical nature at the host location, please complete below:<br>Topic _____<br>Number of hours completed _____<br>**Indicate the number** of health professionals participating in the activity<br>_____medical professionals<br>_____nursing and allied health professionals<br>_____other |

| Continuity of services |
|---|
| If you plan on continuing the service, have future visit date/s been distributed to other local and visiting health professionals so they are aware of your upcoming visit and can refer if needed? |
| If you do not plan on continuing the service, is there a succession plan in place with your host facility? ie. handover of clinal summaries. |
| **Patient information record management** |
| Has appropriate patient information and visit feedback been submitted to the patients referring health practitioner/school?<br>☐ Yes ☐ If no, why not?<br>Has appropriate visit information been uploaded in the patient's My Health Record?<br>☐ Yes ☐ If no, why not? |
| **Please provide comments about this visit** |
| Has there been any changes in patient outcomes (ie behaviour, knowledge, skills, and health status) and/or impact on the community?<br><br>Was the visit implemented as planned – why/why not? (ie workforce concerns, event or weather influences, reasons patients did not attend)<br><br>**Other** |

**Service data to be entered into** the Visit Information Portal