**NT PHN Outcome Report Template**

|  |  |  |
| --- | --- | --- |
| **Service Visit ID Number:** |  | |
| **Service Visit Dates** | **Start Date:** | **End Date:** |
| **Location / Clinic** |  | |
| **Total number of clients seen:** |  | |
| **Number of Aboriginal and Torres Strait Islander clients seen:** |  | |
| **Number of Aboriginal and Torres Strait Islander clients aged 50 and over:** |  | |
| **Number of clients seen in a group session:** |  | |
| **Service Delivery Type:** | Select one or more options:   * Individual chronic condition consultations * Group education session/s * Group consultation/s * Community Engagement * Telehealth consultation * Case Conference * Other, please specify | |
| **Service Delivery Locations:** | Select one or more options:   * Aged Care Centre * Case Conference * Health Care Centre * Home visits * Men’s Centre * Telehealth * Women’s Centre   Other, please specify | |
| **Did you have on-the-ground support during this visit?** | Select one or more options:   * Driver * Aboriginal Health Worker or Practitioner * Chronic Care Coordinator/Chronic Disease Nurse * GP/Remote area medical practitioner * Student * No * Other, please specify | |
| **Did you provide professional support to other health professionals during this visit?**  *Professional support provided by the outreach provider to local health professionals after the delivery of a service e.g. informal discussions regarding patient management.* | Yes  No | |
| **Which health professionals did you upskill during this visit?** | Select one or more options:   * Aboriginal Health Worker * Remote Are Nurse * Chronic Care Coordinator * GP/remote area medical practitioner * Health Centre staff group * Student * N/A * Other, please specify | |
| **Provide a description of the upskilling you provided** | *Free text space* | |
| **Total number of health professionals upskilled on this visit** |  | |
| **Please select the service delivery barriers you faced during this visit** | Select one or more options:   * Community business (*Sorry business, ceremony, community unrest, pay week)* * Transport * Weather * Health Centre * Accommodation * Other, please specify | |
| **Please provide more details on the service delivery barriers you faced during this visit** | *Free text space* | |
| **Please provide suggestions on how to improve the service delivery system and/or quality of care for patients in this location.** | *Free text space* | |
| **Please provide feedback on travel and logistics for this visit, if required** | *Free text space* | |
| **Other feedback** | *Free text space* | |
| **Person Completing the Report:**  **Name:**  **Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | |
| **Privacy Statement:**   * The information we collect on this form will be used by us to reply to the feedback you have provided. It may be disclosed to third parties where it is required of allowed by law or where you have otherwise consented. * As authorised to upload this information on behalf of the service provider, I declare that the above information to be true and correct. | | |