

**Community Equipment Assessors**

**SHORT ASSESSMENT FORM**

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| **Name:**  | **AIS/SWIFT ID:**  |
| **Address:**  | **DOB:**  |
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| **Postcode:**  | **Telephone:**  |

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| **Marital Status:**  |  |
| **NOK details:** (Name, relationship, address, telephone number) |  |
| **Lives:** (Alone, spouse, partner, family, other) |  |
| **Accommodation:** (House, flat, bungalow, other) |  |
| **Ownership:** (LA, PO, HA, Pr Rent) |  |
| **GP details:**  |  |
| **Height :**  | **Weight:**  |

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| **Ethnic Origin:** (X those that apply)  |

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| **White:**  | British  | Irish  | Other  |  |
| **Mixed:** | White / black / Caribbean  | White / black / African  | White Asian  | Other  |
| **Asian or Asian British:**  | Indian  | Pakistani | Bangladeshi  | Other  |
| **Black or black British:**  | Caribbean  | African  | Other  |  |
| **Other Ethnic Groups:**  | Chinese  | Other |  |  |

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| **Medical Condition/s:**  |
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| **Areas / activities assessed:** (X those that apply) |
| Access front / back door |  | Toilet transfers |  | Chair transfers |  |
| Steps  |  | Bathing |  | Kitchen activity |  |
| Stairs |  | Showering |  | Standing tolerance |  |
| Thresholds |  | Bed transfers |  | Mobility needs |  |
| **Can Service User access community services:** (Yes / No) |
| Drives  |  | Family / Friends Take them  |  | Walks  |  |
| Bus |  | Volunteer Driver  |  | Other |  |
| **Any other Needs:**  |
| **Telecare needs**:  |  | **Sensory** : Visual Impairment |  | **Sensory** : Hearing Impairment |  |
| **Benefits in receipt of:** (AA / DLA / Other) |  | **Mental Health issues identified:** (Yes / No) |  | **Safeguarding issues identified:** (Yes / No) |  |
| **Benefits Maximisation Required**  |  | If yes, information passed to: |  | If yes, information passed to: |  |

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| **Functional Difficulties as identified by Service Users:**  |
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| **Agreed Needs:** *i.e. Safe transfers on / off toilet* | **Agreed plan of Action:** *i.e. Ordered 4” RTS* |
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| **Declined / Un–met Needs:** *i.e. Declined grab rail at front door* | **Reasons:** *i.e. Advised that family will make private arrangements to fit* |
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| **Date of Assessment:** |  |
| **Other Agencies referred on to:**  |  |
| **Date Equipment Ordered:**  |  |
| **Date Equipment Delivered:** |  |
| **Date Adaptations Ordered:** |  |
| **Date Adaptations Fitted:** |  |
| **Date(s) of referral to other agency / agencies** *(please list)* |  |
| **Date of Review/s:** *(minimum review will be telephone review 2 weeks after delivery / fitting)* |  |
| **Date of Closure:** |  |

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| **Outcome of Review:** (i.e. happy with equipment / equipment returned etc). |
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**Signed:………………………………………………. Date: …………………………………………...**

 **Service User / Representative**

**Signed:………………………………………………. Date: …………………………………………...**

 **Assessor**

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 **Designation**