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| Occupational Therapy Assessment V13.1 October 2016For use in OT / enablement /rehabilitative contexts |

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| **Client Details** | | | | | | | | | | |
| Title |  | | Forename |  | | | Surname | |  | |
| Date of birth | |  | | | Client ID | : | | NHS Number | |  |

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| **Assessment Details** | |
| Completed by |  |
| Contact details (tel) |  |
| Role / profession |  |
| Team |  |
| Assessment date |  |
| Location of assessment |  |

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| **Communication Needs** | |
| Do you have any communication difficulties? | |
| Communication support required? | \* |
| Specific contact methods required? | \* |
| Support from a communication professional required? | \* |
| Information in a specfic format required? | \* |

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| **Disabilities, Impairments or Health Conditions (Diagnosed)** | | | | | | | |
| **Learning, Developmental or Intellectual Disability** | Autism | | |  |  | | |
| Asperger Synd/High Func Autism | | |  |  | | |
| Learning Disability | | |  |  | | |
| **Long-term Health condition-Physical** | COPD | | |  |  | | |
| Cancer | | |  |  | | |
| Acquired Physical Injury | | |  |  | | |
| HIV/AIDS | | |  |  | | |
| Physical Long Term - Other | | |  |  | | Details |
| **Long-term Health condition - Neurological** | Stroke | | |  |  | | |
| Parkinsons | | |  |  | | |
| Motor Neurone Disease | | |  |  | | |
| Acquired Brain Injury | | |  |  | | |
| Neurological - Other | | |  |  | | Details |
| **Sensory Impairment** | Visually impaired | | |  |  | | |
| Hearing impaired | | |  |  | | |
| Sensory impaired – Other | | |  |  | | Details |
| **Mental Health Condition** | Dementia | | |  |  | | |
| MH Condition - Other | | |  |  | | Details |
| **No Relevant Long-term Reported Health Conditions** | | | |  | | | |
| Height | |  | Weight | | |  | |
| Hand dominance | | Right  Left  Ambidextrous | | | | | |
| **Disabilities, impairments and health conditions** | | | | | | | |

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| **Factors Affecting Functioning and Support Needs** | **Fill in Yes or No** | **Details:** |
| Cognitive and perceptual | Yes  No |  |
| a. Does mental capacity or deprivation of liberty need further consideration?  b. Is referral to a Care Act Independent Advocate required? | Yes  No  Yes  No |  |
| Motor and neuromuscular | Yes  No |  |
| Sensory (including pain) | Yes  No |  |
| Sensory (hearing, vision) | Yes  No |  |
| Psychological (including motivation and self-management) | Yes  No |  |
| Tissue viability | Yes  No |  |
| Sleep (including fatigue) | Yes  No |  |
| Medication | Yes  No |  |
| Social (including communication,  reading and writing) | Yes  No |  |
| Falls | Yes  No |  |
| Health Promotion/Lifestyle | Yes  No |  |

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| **Social Situation** |

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| **Carer’s support (record what the carer assists with in more detail in the ADL sections)** |
| If a carer provides any support offer a carer’s assessment. |

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| **Property Details** | | | | |
| Property Tenure | *:* | Type of Property | | *:* |
| Location and Layout (include sketch as appropriate)  *:* | | | | |
| Front external access (level, stepped or ramped) | | |  | |
| Back external access (level, stepped or ramped) | | |  | |
| Internal access (level or stepped) | | |  | |
| Stairs (including number of treads, width and number of flights) | | |  | |

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| **Assessment Scoring Schema (Optional for Social Care)** | | | | | | | |
| **4**  Independent –  with or without equipment or adaptations | **3**  Struggling independence –  arouses concern | | | **2**  Minimum assistance –  some risks without help | | **1**  Maximum assistance –  at risk without help | **0**  Dependent –  at severe risk without help |
| X = not assessed R = reported O = observed | | | | | | | |
| **Mobility** | | Current Score | Last Score | |  | | |
| Indoor mobility and aids used | | \* | \* | | \* | | |
| Stair mobility | | \* | \* | | \* | | |
| Entering and exiting home | | \* | \* | | \* | | |
| Outdoor mobility and aids used | | \* | \* | | \* | | |

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| **Transfers** | Current Score | Last Score |  |
| Bed – type, method and equipment used | \* | \* | \* |
| Chair/posture/seating – type, method and equipment used | \* | \* | \* |
| WC – type, method and equipment used | \* | \* | \* |
| Bath/shower – type, method and equipment used | \* | \* | \* |

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| **Self-Care** | Current Score | Last Score |  |
| Eating and drinking | \* | \* | \* |
| Toilet hygiene and continence | \* | \* | \* |
| Washing | \* | \* | \* |
| Dressing | \* | \* | \* |
| Personal grooming (including mouth care and foot care) | \* | \* | \* |
| Personal health care (including medication and dressings) | \* | \* | \* |

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| **Domestic Activities** | Current Score | Last Score |  |
| Preparing snacks and drinks | \* | \* | \* |
| Preparing meals | \* | \* | \* |
| Housework and laundry | \* | \* | \* |
| Garden and home maintenance | \* | \* | \* |
| Financial situation and money management (include paying bills) | \* | \* | \* |
| Use of heating | \* | \* | \* |

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| **Family, Community and Work Activities** | Current Score | Last Score |  |
| Shopping | \* | \* | \* |
| Getting to appointments | \* | \* | \* |
| Use of public transport / car | \* | \* | \* |
| Recreation and leisure | \* | \* | \* |
| Employment/training/  education/volunteering | \* | \* | \* |
| Caring responsibilities the adult has for a child | \* | \* | \* |
| Developing and maintaining family or other relationships | \* | \* | \* |

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| **Moving and Handling** |  |
| Equipment used |  |
| Risks identified |  |
| Risk assessment(s) completed (including where completed assessment(s) can be found) |  |
| Moving and handling plan(s) completed |  |

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| **Assistive Technologies** |  |
| Lifeline / Telecare |  |
| Environmental control systems |  |
| Internet / telephone use |  |

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| **Eligibility Criteria (if OT service is not a preventative service)** | |
| Does this person have eligible needs?  (Yes or No) | Yes  No |
| **Please attach Eligibility Criteria decision form to this document.** | |

**Occupational Therapy Action/Intervention Plan**

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| --- | --- |
| Name: | Client ID: |
| **Goals** | **Action** |
|  |  |

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| Action/Intervention Rejected and reason |  |

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| Your Signature: | | Date: | | Or: Signature, name & status of legal representative\*: | | Date: |
| Assessor’s signature and printed name: | | Date: | | Or: If the person does not have a legal representative: This document has been agreed by all parties\*\* as in ………………’s (name of service user) best interests.  Signature, name & status of decision-maker: | | Date: |
| Authorised by signature and printed name: | | Date: | | Date: |
| Completed by: |  | | Contact Details (Tel): | |  | |
| Role/Profession: |  | | Care/Support Team | |  | |
| Please note: if you are a paper user of this form there is a code list available on KNet which shows all the options listed in the drop down boxes marked with an asterisk (\*) | | | | | | |

\*A legal representative is someone who: Has LPA (Personal Welfare for the purpose of this document), holds a Personal Welfare deputyship or has been specifically authorised by order to the Court of Protection.

\*\*name the parties in the service user’s case file.