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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.