1. **Contact Details**

|  |  |  |  |
| --- | --- | --- | --- |
| Title  Mr  Mrs  Ms Miss | Forenames | Surname | DOB  Age |
| Likes to be called | Gender :  M  F | Ethnic Origin | Religion |

|  |  |
| --- | --- |
| Home Address  Postcode Tel No | Current Address (If different)  Postcode Tel No |
| Allergies | Disability |

|  |  |  |  |
| --- | --- | --- | --- |
| Assessed at: | Home | Hospital | Nursing/Res Home |

|  |  |  |
| --- | --- | --- |
| In the presence of:  (please provide details) | Son | Daughter |
| Nurse | Friend | Other |

|  |  |
| --- | --- |
| GP Name: | Next of Kin Name |
| Practice name:  Address:  Postcode | Relationship:  Address:  Postcode |
| Tel No: | Tel No: |
| Contact person in case of emergency  Name:  Relationship:  Tel No: | Other: |

1. **Communication issue**

* Describe the person’s ability with hearing, speech, sight, communication and understanding.
* Are there any sensory impairments (speech/verbal or intellectual)?
* Is the person able to read or write?

|  |  |
| --- | --- |
| Do you have any significant hearing problem? |  |
| Do you use hearing aids? |  |
| Do you have any visual problems? |  |
| Are you registered blind? |  |
| Do you have glaucoma? |  |
| Do you suffer from dementia? |  |

1. **Access and Mobility**

* Describe the person’s mobility and ability needs.
* Also, include comments on access and transport matters for social purposes.
* Identify risk factors (history of falls, are they safe to be left alone)
* Include equipment used

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Mobility** | **Able** | **With 1** | **With 2** | **Unable** | **Comments** | **Observed** |
| In and out of house |  |  |  |  |  |  |
| Around the house |  |  |  |  |  |  |
| Chair in/out |  |  |  |  |  |  |
| Stairs up/down |  |  |  |  |  |  |
| Bed in an/out |  |  |  |  |  |  |
| In and out of car |  |  |  |  |  |  |

1. **Personal care**

* Identify the person’s ability in relation to daily routines (activities of daily living)
* Identify equipment used.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Personal care** | **Capable** | **With 1** | **With 2** | **Incapable** | **Comments** | **Observed** |
| Dressing |  |  |  |  |  |  |
| Undressing |  |  |  |  |  |  |
| Washing |  |  |  |  |  |  |
| Oral/mouth care |  |  |  |  |  |  |
| Grooming/hair care |  |  |  |  |  |  |
| Toilet or commode |  |  |  |  |  |  |
| Bathing /showering |  |  |  |  |  |  |
| Taking medication |  |  |  |  |  |  |
| Ability to call for help |  |  |  |  |  |  |

1. **Domestic needs**

* Identify the person’s needs and ability to perform daily duties

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Domestic needs** | **Capable** | **Incapable** | **Comments** | **Observed** |
| Meal preparation |  |  |  |  |
| House work |  |  |  |  |
| Washing/ironing |  |  |  |  |
| Fires heating |  |  |  |  |
| Shopping |  |  |  |  |
| Disposing of  household rubbish |  |  |  |  |

1. **Health and Social Issue**

* Describe aspects of the person’s ability and how this affect their daily life. Does this vary and what are their care needs? Comment upon any social and risk factors, i.e., current housing needs, social relationships. Is care available at required intervals? Can the person be left alone?

|  |
| --- |
|  |

1. **Medical History and Diagnosis**

* Include all past treatments and diagnosis.
* Also highlight any future tests, treatments or scans
* Note any pending results and need to ACTION on them

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|  |

1. **Emotional Well-being and mental health**

* Describe aspects of the person’s wellbeing and mental health with regard to depression, anxiety, cognitive impairment and memory loss.
* Include the person’s social views and interests
* Highlight if the person can be safely left ALONE!

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|  |

1. **Summary of assessed needs and care planning**

* Evaluate the needs identified and those of care
* Include current needs and potential future needs

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