ASSESSMENT FOR OLDER PERSONS IN NEED OF CARE AND/OR SUPPORT SERVICES **FORM A**

Name and surname:		**ID number:**	
Date of assessment:			

Place of assessment:		**Assessment completed by:**	
Own dwelling		Name:	
Home for Aged		Professional qualification:	
Sheltered accommodation		Contact number:	
Community centre		Email:	
Hospital		Employer:	
Clinic		Role with employer:	
Other			

Those present at assessment besides the client and assessor:	Name & Surname	Role / Relationship	Contact details

ABOUT ME											
Title	Mr		Mrs		Ms		Prof		Dr		Rev	
	Other											
Full name					**Surname**							
Known as					***ID Number***							
Date of birth					**Age**							
Home number					***Mobile number***							
Email Address												
Marital Status	*Married*		*Divorced*		*Widowed*		*Single*		*Civil Partnership*			
Main Language												
Other languages	*2nd*						*3rd*					
Gender	Male		Female		*Other*							
Race/Ethnicity	*Asian*		*Black*		*Coloured*				*White*			
Current Home Address												
Type of current accommodation	Owner		Tenant		House		Flat					
	Retirement home or complex		Private home / guest house / hotel		Informal / Squatter settlement		Housing scheme					
	Tribal (rural)		Farm labourer		Old age home		Other:					

Access to primary needs:	Water	Food	Toilet	Safety	Key
	0	0	0	0	Available
	11	11	8	10	Limited
	22	22	16	20	Inaccessible
~~Not applicable~~	28	28	20	24	Not available
	Total score for Primary Needs: (A)				

Access to Community infrastructure	Transport	Telephone	*Internet*	Post office	*Clinic*	Key
						Available
						Limited
						Inaccessible
~~Not applicable~~						Not available

Household **composition**	Lives alone		With spouse / partner		With children/child		With other family	
	With other older persons		With non-family (friends)		Extended family		Rural extended family	
	With parents		Number of persons in the household		*Number of pets in the household*		*Type of animals:*	
Employment status	*Retired*		*Part time employed*		*Self employed*		*Full time employed*	
	Not applicable		*Not employed*					

Finances	Source of income:	Disability Grant		Old Age Pension		War veterans		Other (private)

Gross income per month:	Individual:		Couple:	
Total monthly income per household				
Details of financial dependents				

Medical Aid		*Medical Aid Plan*		
	Main Member		*Medical Aid Number*	

Curatorship required	*Yes*		*Curatorship in place*	*Yes*	
	No			*No*	
	Curator Name		*Curator telephone*		

Religion	Christian		Muslim		Jewish		Buddhist	
	Mormon		Jehovah Witness		Traditional African		Other	
Major life events	*Divorce*		*Death of spouse/ Partner*		*Death of child*		*Death of close family member*	
	Death of close friend		*Death of Pet*		*Other*	Please specify		

Needs identified by client	

ABOUT MY BODY								
Please indicate with which of the following, if any, you have difficulties/challenges with:								
Nervous system:								
Stroke	Yes		*Dystrophy*	Yes		*Paralysis*	Yes	
	No			No			No	
Headaches	Yes		*Blackouts*	Yes		*Epilepsy*	Yes	
	No			No			No	
Porphyria	Yes		*Pain*	Yes		*Other*		
	No			No				
Cardiovascular system:								
Angina	Yes		*Anaemia*	Yes		*Coronary thrombosis*	Yes	
	No			No			No	
Rheumatic fever	Yes		*Congenital defects*	Yes		*Pacemaker*	Yes	
	No			No			No	
High/low blood pressure	Yes		*Blood thinning medication*	Yes		*Other*		
	No			No				
Lymphatic system								
Oedema	Yes		*Other*					
	No							

Urinary system								
Kidney stones	Yes / No		Bladder: discharge/bleeding	Yes / No		Urostomy	Yes / No	
Catheter	Yes / No		Continent of urine	Yes / No		Other		

Skeletal system								
Arthritis	Yes / No		*Osteoporosis*	Yes / No		*Back pain*	Yes / No	
Restrictive movement (stiff joints)	Yes / No		If yes, please specify					
Teeth problems	Yes / No		If yes, please specify					
Other								
Endocrine system								
Thyroid problems	Yes / No		*Diabetes*	Yes / No		*If yes, please specify*	*Type 1* / *Type 2*	
Other								
Respiratory system								
Asthma	Yes / No		*Bronchitis*	Yes / No		*Emphysema*	Yes / No	
TB	Yes / No		*Cyanosis*	Yes / No		*Dyspnea*	Yes / No	
Other								
Digestive system								
Gastric / duodenal ulcers	Yes / No		*Hiatus hernia*	Yes / No		*Weight change (in last 3 months)*	Yes / No	
Loss of appetite (last 3 months)	Yes / No		*Special textured food required*	Yes / No		*Nausea / vomiting*	Yes / No	
Chewing, sucking, or swallowing problems	Yes / No		*Colostomy/stoma*	Yes / No		*PEG*	Yes / No	
Hepatitis	Yes / No		*Jaundice*	Yes / No		*Continent bowel movement*	Yes / No	
Other								
Reproductive system								
Bleeding / discharge	Yes / No		*Genital complaints*	Yes / No		*Other*		
Integumentary system								
Skin integrity intact	Yes / No		*Wounds*	Yes / No		*Details*		
Pressure sores	Yes / No		*Details*					
Hair issues	Yes / No		*Nail issues*	Yes / No		Other		
Muscular system								
Dystrophy	Yes / No		*Other*					
Senses:								
Problems with eyes& vision	Yes / No		*Details (include any assistive devices used)*					
Problems with nose & smell	Yes / No		*Details (include any assistive devices used)*					

Problems with skin & touch	Yes / No		*Details (include any assistive devices used)*	
Problems with mouth / tongue & taste	Yes / No		*Details (include any assistive devices used)*	
Problem with ears & hearing	Yes / No		*Details (include any assistive devices used)*	

Weight		*Height*			*BMI:*		
Life-threatening disease?	Yes / No	*Person aware of life-threatening diagnosis*	Yes / No		*Palliative stage*	Yes / No	

Falls:

Number of falls during the last week:		*Number of falls during the last month:*		*Number of falls during the last year:*	
Reasons for falls:					
Any injuries sustained during these falls? Please specify					
Other medical condition / diagnosis / comments					

ABOUT MY MIND

Depression	Yes / No		*Bipolar*	Yes / No		*Schizophrenia / other psychoses*	Yes / No				
Dementia	Yes / No		*Developmental*	Yes / No		*Eating disorder*	Yes / No				
Personality disorder	Yes / No		*Anxiety*	Yes / No		Substance dependency	Yes / No		*Alcohol*		*Drugs* / *Other*	
									Tobacco		

Mental functioning	No support required			0
	Observes accepted social standards with support			3
	Behaviour is unusual but does not offend others or endanger self			3
	Behaviour disturbing to others at times but not a danger to self or others			13
	Continuous, uncontrollable, demanding behaviour			23
	Behaviour dangerous / risk to him/herself / other people			25
Summary Mental observation by Assessor	REMARKS: Please circle as appropriate	Lonely / Depressed / Aggressive / Anxious / Anti-social / OCDC / Markedly unmotivated	**Total for Mental Functioning (B)**	
Other medical condition / diagnosis / comments	Would the client benefit from a psychiatric assessment? Y / N			

Chronic medication	*Yes* / *No*		*Acute medication*	*Yes* / *No*		*Daily intake*	*0*	*1*	*2*	*3-5*	*5+*

MY DAILY ACTIVITIES – Activities of Daily Living

Eating	Dressing upper	Dressing lower	Personal hygiene	Bathing/ Showering	Toileting	Key
0	0	0	0	0	0	Fully independent
3	1	2	2	3	3	Independent with aid-devices
3	1	2	2	3	3	Needs supervision, but can manage on own
3	2	3	2	5	5	Needs regular supervision and help with certain tasks
10	3	4	6	8	8	Needs help of one person
N/A	6	8	N/A	10	10	Needs help of two persons
13	N/A	N/A	10	13		Needs continuous care (e.g. Naso-gastric or PEG)
+	+	+	+	+	+	

Medication	Mobility	Communica-tion	Transfers	*Drinking*	*Sleeping*	Key
0	0	0	0			Fully independent
3	2	2	0			Independent with aid-devices
5	4	N/A	2			Needs supervision, but can manage on own

8	6	6	2			Needs regular supervision and help with certain tasks
10	6	6	9			Needs help of one person
N/A	8	N/A	1			Needs help of two persons
13	10	10	N/A			Needs continuous care (e.g Naso-gastric or PEG)
+	+	+	+	**TOTAL SCORE: "ADLs" (C)**		

Extended ADLs – Independence in performing

Lawton –Brody Instrumental Activities of Daily Living Scale (IADL) (alz.org) Best Practices in Nursing Care to Older Adults, The Hartford Institute for Geriatric Nursing, New York University, College of Nursing,www.hartfordign.org.

A: Ability to use the telephone		***B: Shopping***	
1.Operates telephone on own initiative-looks up and dials numbers, etc.	1	*1.Takes care of all shopping needs independently*	1
2. Dials a few well-known numbers	1	*2.Shops independently for small purchases*	0
3. Answers telephone but does not dial	1	*3.Needs to be accompanied on any shopping trip*	0
4. Does not use telephone at all	0	*4.Completely unable to shop*	0
C: Food preparation		***D: Housekeeping***	
1. Plans, prepares and serves adequate meals independently	1	*1.Maintains house alone or with occasional assistance (e.g. "heavy work domestic help")*	1
2. Prepares adequate meals if supplied with ingredients	0	*2. Performs light daily tasks such as dish washing, bed making*	1
3. Heats, serves and prepares meals, or prepares meals, or prepares meals but does not maintain adequate diet	0	*3. Performs light daily tasks but cannot maintain acceptable level of cleanliness*	1
4. Needs to have meals prepared and served	0	*4. Needs help with all home maintenance tasks*	1
		5. Does not participate in any housekeeping tasks	0
E: Mode of transport		***F: Laundry***	
1.Travels independently on public transportation or drives own car	1	*1.Does personal laundry completely*	1
2. Arranges own travel via taxi, but does not otherwise use public transportation	1	*2. Launders small items-rinses stockings, etc.*	1
3. Travels on public transportation when accompanied by another	1	*3. All laundry must be done by others*	0
4. Travel limited to taxi or automobile with assistance of another	0		
5. Does not travel at all	0		
G: Ability to handle finances		***H: Responsibility for own medications***	
1.Manages financial matters independently	1	*1. Is responsible for taking medication in correct dosages at correct time*	1
2.Manages day-to-day purchases, but needs help with banking, major purchases, etc.	1	*2. Takes responsibility if medication is prepared in advance in separate dosage*	0
3.Incapable of handling money	0	*3. Is not capable of dispensing own medication*	0
		TOTAL SCORE FOR "EADLs"	

'A summary score ranges from 0 (low function, dependent) to 8 (high function, independent) for women and 0 through 5 for men to avoid potential gender bias.'

ABOUT MY PEOPLE AND MY COMMUNITY

Next of kin 1	Name:		Relationship:	
	Age:		Contact no.:	
	Address:			
	Email:			
Next of kin 2	*Name:*		*Relationship:*	
	Age:		*Contact no.:*	
	Address:			
	Email:			

General functioning of caregiver	Caregiver fully in control of the situation*/No care giver required*	0	Requires some support	7	Not healthy / aged / living with a disability	7

	Requires continuous support /help	40	Total incapacity to provide care	67	Total burnout institution,	67
~~Not applicable~~	**Score (i):**					
Support systems available to older person ~~Not applicable~~	Support system (*institution,* spouse, family, friends) functioning well	0	Support system available, but not functioning well	20	Living alone with access to other support systems	3
	Only formal support system	13	Support system available, but exploitation /abuse / neglect suspected	33	No support system available	26
	Score (ii):		**TOTAL SCORE** (i) + (ii) =		**(D)**	

Social challenges: *"Lubben social network scale "* *lubben_social_network_scale.pdf (connectingedmontonseniors.ca)* *The score ranges between 0 and 30, with a higher score indicating more social engagement.*	***Family:*** *Considering the people to whom you are related by births, marriage, adoption etc.:*	*How many relatives do you see or hear from at least once a month?*	***None***	*0*	*How many relatives do you feel at ease with that you can talk about private matters?*	***None***	*0*
			1	*1*		***1***	*1*
			2	*2*		***2***	*2*
			3 or 4	*3*		***3 or 4***	*3*
			5 to 8	*4*		***5 to 8***	*4*
			9 and more	*5*		***9 and more***	*5*
	Friendships: *Consider all of your friends including those who live in your neighbourhood:*	*How many of your friends do you see or hear form at least once a month?*	***None***	*0*	*How many friends do you feel at ease with that you can talk about private matters?*	***None***	*0*
			1	*1*		***1***	*1*
			2	*2*		***2***	*2*
			3 or 4	*3*		***3 or 4***	*3*
			5 to 8	*4*		***5 to 8***	*4*
			9 and more	*5*		***9 and more***	*5*
'A score of 12 and lower delineates "at-risk" for social isolation.'			***Total score:***				

Communication - choose one	*Details about communication:*
A. Able to communicate desires/needs B. At times unable to communicate desires/needs C. Total absence of communication	

Any other relevant information or observations relating to the assessment:

Others who gave input during assessment process					
Role	**Name**	***Input***	*Report received*	***Recommendations***	*Report received*
Family practitioner					
District surgeon					
Nursing personnel					
Psychiatrist					
Geriatrician					
Traditional healer					
Social worker					
Old age home personnel					

Physiotherapist					
Family members					
Care workers					
Home care personnel					
Other:					

Older persons' opinion or perception of desired outcomes:

Criteria for *'urgent'* admission to long-term care: Skilled care										
1. Pressure care / turning of person				**2. Specialized care**						
0	Nil needed			0	Nil needed					
11	1 to 3 x per day			11	Simple, daily treatment or dressing					
22	Every 4 hours			42	Requires complicated treatment or dressing more than 3 x per day					
33	Every 2 hours									
3. Night-care:				***4.Oxygen-usage***						
0	Nil needed				*Nil needed*					
5	Regular, 1 x per night care required				*1 -3 x per day / as needed*					
10	Regularly requires attention at least 3 x per night				*Every 4 hours / Less than 12 hours*					
25	Usually awake, restless, disturbs others				*Every 2 hours / more than 12 hours*					
Total score "Skilled care"	1:	+	2:	+	3:			=	**(E)**	

ASSESSMENT FOR SERVICE REQUIREMENT *(DQ98 METHOD)*			
Score for Primary needs: **A** pg. 1		x 0.15	=
Score for Mental functioning: **B** pg. 4		x 1	=
Score for ADLs: **C** pg. 4		x 0.25	=
Score for Carer: **D** pg. 5		x 0.15	=
Score Skilled care: **E** pg. 7		x 0.2	=
SCORE Total			

Support and care services already in use:					
Support groups	Yes	No	Hospital care	Yes	No
Catering (at home) – Meals on wheels	Yes	No	Respite (Relief)	Yes	No
~~Home~~ *Domestic* help	Yes	No	*Residential care with full support* ~~(Frail care)~~	Yes	No
Home based care (personal care)	Yes	No	Day care (at home)	Yes	No
Full Care (at home)	Yes	No	Day care (Centre)	Yes	No
Other					

FINDINGS					
Requires ~~institutional~~ care / support	Yes		Period care required for	Temporary	
	No			Permanent	
RECOMMENDATIONS					
~~Institutional~~ *Residential* care	Yes	No	***Urgency of service provision***		
Home based care	Yes	No	*Within 24 hrs*		
Respite (care-giver relief)	Yes	No	*Within 1 week*		
Rehabilitation	Yes	No	*Within 1 – 3 weeks*		
Palliative	Yes	No	*Other*		

~~Terminal~~ *End of Life*	Yes	No	

Referral to community support services				
GP assessment required?	Yes No		*Reason for referral:*	
Psychiatric assessment required?	Yes No		*Reason for referral:*	
Social Services required?	Yes No		*Reason for referral:*	
Occupational therapist (OT) required?	Yes No		*Reason for referral:*	
Podiatrist required?	Yes No		*Reason for referral:*	
Audiologist assessment required?	Yes No		*Reason for referral:*	
Physiotherapist required?	Yes No		*Reason for referral:*	
Optometrist assessment required?	Yes No		*Reason for referral:*	
After-care rehabilitation	Yes		*Reason for referral:*	
Support groups	Yes No		*Reason for referral:*	
Day care (at home)	Yes No		*Reason for referral:*	
Catering (at home) – Meals on wheels	Yes No		*Reason for referral:*	
Home help	Yes No		*Reason for referral:*	
~~Frail care~~ Full Care in Care Centre ~~(Institutional)~~	Yes No		*Reason for referral:*	
Hospital care	Yes No		*Reason for referral:*	
Day Care (Care Centre)	Yes No		*Reason for referral:*	
Respite care (Relief)	Yes No		*Reason for referral:*	
Clinic services	Yes No		*Reason for referral:*	
Other	Yes		*Reason for referral:*	

Any other recommendations relating to the assessment:

Re-assessment date:	

Conclusion of Assessment:

Assessor: I have discussed the current assessment and recommendations with the individual / caregiver and have indicated the right to appeal.

Name		Date:	

Signature			
Role and organisation			
Contact details			
Older Person / Caregiver: I have discussed the current assessment and recommendations with the assessor. Please delete as appropriate:			
I agree / disagree with the recommendations.			
I agree / disagree that the assessment form be referred to appropriate services as indicated above.			
I agree / disagree that the assessment form be referred to the following organisation:			
I agree / disagree that my information may be utilised expressly for the purpose of my personal care plan.			
Motivate: (if disagree)			
Signature or *thumb print*:		Date:	