ASSESSMENT FOR ADMISSION TO HOMES FOR FRAIL PERSONS/SUPPORT NEEDS FOR OLDER PERSONS DQ98

Do not write in the shaded areas. Tick where appropriate	1998 Dept of Welfare

SECTION 1: REGISTRATION DETAILS

A. ORGANISATION: Kensington Home For The Aged	Registration No: NPO 026-367	Date of Registration:
Date of notification:	Assessment completed on:	Date of admission:

Type of Assessment:		**Urgency:**		**Place of Assessment:**			
	New notification		Within 24 hours		Own dwelling		Hospital
	Revision		Within 1 week		Home for the Aged		Clinic
	Re-assessment		Within 1-3 weeks		Sheltered accommodation		Other
	Appeal		Other		Community Centre		

Reason for referral Assessor's name: Occupation:	Reference Source:

B. CLIENT PERSONAL DETAILS:				**Centre member**
Surname:		Marital Status:		**Nursing Services**
Full Name: First name and Initials: Address:				**Group (Club)** **Social worker** **Church** **Hospital**
Tel No:				**Family member**
Date of birth/Age:		Gender:	**M** / **F**	Other

Race (for statistical purposes)					**ACCOMODATION:**		FAMILY COMPOSITION:	
						Owner		Lives in old age home
SOURCE OF INCOME:		**GROSS INCOME PER MONTH:**				Tenant		Lives alone
	Disability Grant		Individual	Couple		House		With spouse
	Old Age Pension	Total monthly Income per household:				Flat		With children/child
	War Veterans	R				Retirement complex		With other family
	Other (private)					Private home/guest house/hotel		With other elderly
Specify details of financial dependents:						Informal /Squatter settlement		With non-family (friends)
						Housing scheme		Extended family
						Tribal (rural)		Rural extended family
						Farm labourer		With parents
						Old age home		Please state number of persons in the household:
						Other: Frail Care		

MEDICAL CONDITIONS / OTHER PROBLEMS

C. NEEDS IDENTIFIED BY CLIENT		Additional information obtained from:		
		Applicant him/herself		Caregiver
		Family		Social worker
		Medical personnel		Other

D. DETAILS REGARDING NEXT OF KIN / CARE-GIVER

Next of kin:

Relationship: Age (Optional):

Address:

Telephone no: Work: Home:

SECTION 2: ASSESSMENT:

A. Urgent Evaluation Criteria

	Bedbound
	Mentally disabled with total incontinence
	Chronic high risk medical conditions requiring continuous nursing care

Medical conditions / diagnosis:

B. CRITERIA FOR ADMISSION: 1. SKILLED CARE

a. Pressure care

0	Nil needed
11	1 to 3 x per day
22	Every 4 hours
33	Every 2 hours

c. Night care

0	No or infrequent night care required
5	Regular, 1 x per night care required
10	Regularly requires attention at least 3 x per night
25	Usually awake, restless, disturbs others

Total Score 'Skilled care'	a:	+	b:	+	c:	=	

b. Specialised care:

0	Requires no care/dressing
11	Simple, daily treatment or dressing
42	Requires complicated treatment or dressing more than 3 x a day

Other specialised care required / comments:

Current medication:

2. ACTIVITIES OF DAILY LIVING (ADLs)

Eating	Dressing upper	Dressing lower	Personal Hygiene	Bathing	Toileting	Medications	Mobility	Communica tions	Transfers	
0	0	0	0	0	0	0	0	0	0	Fully independent
3	1	2	2	1	3	3	2	2	0	Independent with aid-devices
3	1	2	2	1	3	5	4	N/A	2	Needs supervision, but can manage on own
3	2	3	2	2	5	8	6	6	2	Needs regular supervision and help with certain tasks
10	3	4	6	4	8	10	6	6	9	Needs help of one person
N/A	6	8	N/A	6	10	N/A	8	N/A	11	Needs help of two persons
13	N/A	N/A	10	N/A	13	13	10	10	N/A	Needs continues care
										SCORE FOR EACH ITEM
										TOTAL SCORE FOR 'ADLs'

REMARKS:

NONE

3. MENTAL FUNCTIONING

0	No support required
3	Observes accepted social standards with support
3	Behaviour is unusual but does not offend others or endanger self
13	Behaviour disturbing to others at times but not a danger to others and self
23	Continues uncontrollable, demanding behaviour
25	Behaviour dangerous / risk to him/herself / other people
	REMARKS: eg Markedly unmotivated/depressed/aggressive Patient 'does not like people'

Yes	**No**	Would the client benefit from a Psychiatric Assessment?

TOTAL SCORE for 'Mental Functioning'

4. PRIMARY NEEDS			Not applicable (institutionalised)	
Water	Food	Toilet	Safety	Key
0	0	0	0	Available
11	11	8	10	Limited
22	22	16	20	Inaccessible/dangerous
28	28	20	24	Not available
TOTAL SCORE FOR 'PRIMARY NEEDS'				

5. COMMMUNITY INFRASTRUCTURE			Not applicable (institutionalised)
Transport	Telephone	Post Office	
			Available
			Limited
			Inaccessible
			Not available

6. SUPPORT SYSTEMS AVAILABLE TO CLIENT	
0	Support system (spouse, family, friends) functioning well
20	Support system available, but not functioning well
3	Living alone with access to other support systems
13	Only formal support systems
33	Support system available, but exploitation/abuse/neglect suspected
26	No support system available
	Section 6 score

7. GENERAL FUNCTIONING OF CARE-GIVER	Not applicable (institutionalised)
0	Care-giver fully in control of the situation
7	Requires some support
7	Not healthy/aged/disabled
40	Requires continuous support/help
67	Total incapacity to provide care
67	Total burnout
	Section 7 score
	TOTAL SCORE Section 6+7 'Carer'

8. OTHER PERSONS INVOLVED IN ASSESSMENT			
	Family Practitioner		Physiotherapist
	District surgeon		Social worker
	Nursing personnel		Old age home personnel
	Specialist geriatrician/psychiatrist		Care-giver
	Traditional healer		Home care personnel

SECTION 3: KEY TO ASSESSMENT FOR SERVICE REQUIREMENT				**FINDINGS:**			
Score from 'Skilled' (Section 1)		X 0.2		Requires institutional care	YES	NO	
Score from 'ADLs' (Section 2)		X 0.25		If Yes, Specify care type required : Frail Care			
Score from 'Mental' (Section 3)		X 1		Temporary		Permanent	
Score from 'Primary' (Section 4)		X 0.15		Respite (care-giver relief)		Terminal	
Score from 'Carer' (Section 6 & 7)		X 0.15		Rehabilitation			
DQ98 INDEX SCORE		Total					

SECTION 4: RECOMMENDATIONS: (to be completed by Social Worker from Department of Health)			
Admission to home of the aged	Referral for community health services		
If admission recommended	Community services	Yes	No
Urgent	Medical services	Yes	No
As soon as possible	Geriatric services	Yes	No
Other:	Psychiatric services	Yes	No
Reassess Date:	Referred to:		Date:
Community support service recommendation:			
No additional support services recommended	Additional support by means of certain home services		
Indicate which services are currently 'in use' or 'required'			

	Required	In Use		Required	In Use		Required	In Use
Day care (at home)			Daye car (centre)			Occupational therapist		
Meals-on-wheels			Respite care (relief)			Physiotherapist		
Home help			Nursing services			After-care rehabilitation		
Bed bath (personal care)			Social work care			Garden services		
Frail care (institutional)			Other			Assisted living		
Hospital care			Centre programmes (clubs)			Support group		

SECTION 5: CONCLUSION OF ASSESSMENT Delete appropriate

Assessor: I have discussed the current assessment and recommendations with the applicant/care-giver and have indicated the right to appeal.

Signature: ……………………………… Date:……………………….

Applicant/care-giver: I have discussed the assessment, recommendations and appeal with the assessor.

I agree / disagree with the recommendation

I agree / disagree that the assessment form be referred to Community Services.

I agree / disagree that the assessment form be referred to the following organisation:………………………………………………………

Motivate (if disagreement)……….

Signature: …………………………… Date: …………………………...

Client referred to: ………………………………………………………………. Date: ……………………………