

Functional Assessment Summary

This supplementary template is sent with referrals that occur following assessment of the client's functional abilities and need for assistance. The assessing agency may attach additional assessment summaries covering other domains of client need that are relevant to the referral.

<p>Consumer</p> <p>Name: _____</p> <p>Date of Birth: dd/mm/yyyy / /</p> <p>Sex: _____</p> <p>UR Number: _____</p> <p style="text-align: right;">or affix label here</p>

Rating of Functional Abilities

Notes on ratings:

- Tick one response for each activity (example: housework, transport, shopping etc.)
- Rate what the person is currently capable of doing rather than what they actually do. In addressing capability for any item, take into account not only physical function but also cognition (such as problems caused by dementia or an intellectual disability) and behaviour (such as unpredictable challenging behaviour). People able to complete a task only with verbal prompting should *not* be rated as independent.
- If unable to rate an activity, leave it blank.

Assessment notes: Use the notes section to describe client's specific need for assistance as well as other factors impacting on level and type of need e.g. use of aids and equipment/home modifications; assistance provided by carers/other agencies.

Activity	Rating (✓ one)	Domestic Care
1. Housework	<input type="checkbox"/>	Can maintain house without help or supervision (including laundry)
	<input type="checkbox"/>	Needs some help or supervision
	<input type="checkbox"/>	Completely unable to do housework
2. Transport	<input type="checkbox"/>	Without help (drives own car, travels independently on public transport or taxis)
	<input type="checkbox"/>	With some help (need someone to help or accompany when traveling)
	<input type="checkbox"/>	Completely unable to travel (unless arrangements are made for a specialized vehicle like an ambulance)
3. Shopping (assuming client has transport)	<input type="checkbox"/>	Can take care of all shopping needs
	<input type="checkbox"/>	With some help (need someone to go with client on all shopping trips)
	<input type="checkbox"/>	Completely unable to do any shopping
4. Meal Preparation	<input type="checkbox"/>	Without help (incl planning/preparing/cooking, adequacy of meals and serving)
	<input type="checkbox"/>	With some help
	<input type="checkbox"/>	Completely unable to do any meal preparation, serving or manage nutrition
5. Taking Medications	<input type="checkbox"/>	Without help (in the right doses at the right time)
	<input type="checkbox"/>	With some help (e.g. if someone prepares or reminds client)
	<input type="checkbox"/>	Completely unable to take own medicines without help
6. Handling Money	<input type="checkbox"/>	Without help (writing cheques, paying bills, banking, keeping track of finances)
	<input type="checkbox"/>	With some help (manage day-to-day buying but need help with chequebook and paying bills)
	<input type="checkbox"/>	Completely unable to handle money
7. Telephone	<input type="checkbox"/>	Without help (making and receiving phone calls & incl use of assistive devices)
	<input type="checkbox"/>	With some help
	<input type="checkbox"/>	Completely unable to use the telephone
8. Mobility/Walking	<input type="checkbox"/>	Without help, except for the use of a cane
	<input type="checkbox"/>	With some help from a person (physical or verbal), or with the use of a walker or crutches. If in a wheelchair, tick this rating if the person manages independently including cornering.
	<input type="checkbox"/>	Completely unable to walk. If in a wheelchair, tick this rating if the person is not independent but must be pushed.
9. Mobility: bed/chair transfers	<input type="checkbox"/>	No help needed
	<input type="checkbox"/>	Needs some help
	<input type="checkbox"/>	Unable to manage – no sitting balance

Assessment notes – Domestic Care:

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This information collected by:		Supplementary Form Page 1 of 2	
Name: _____	Position/Agency: _____		
Sign: _____	Date: dd/mm/yyyy / /	Contact number: _____	

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Activity	Rating (✓ one)	Personal Care
10. Self-care screening question	<input type="checkbox"/>	No (→ skip the personal care items and go to Q16)
	<input type="checkbox"/>	Yes (→ proceed to the following personal care items)
	<input type="checkbox"/>	Without help (include in and out of shower or bath and washing unsupervised)
11. Bathing	<input type="checkbox"/>	With some help (e.g. need help getting in or out of the bath)
	<input type="checkbox"/>	Completely unable to bathe without help
	<input type="checkbox"/>	Without help (incl buttons, zips, laces)
12. Dressing	<input type="checkbox"/>	With some help (e.g. help with buttons etc. but can put on some garments alone)
	<input type="checkbox"/>	Completely unable to dress
	<input type="checkbox"/>	Without help
13. Eating	<input type="checkbox"/>	With some help (e.g. help cutting up food, spreading butter, pouring drink)
	<input type="checkbox"/>	Completely unable to eat without help (e.g. spoon feeding)
	<input type="checkbox"/>	Without help (includes on and off, dressing and cleans self)
14. Toilet use	<input type="checkbox"/>	With some help
	<input type="checkbox"/>	Completely unable to manage toileting without help
	<input type="checkbox"/>	Completely continent including self management of catheter or ostomy. Rate based on last week.
15. Continence (bowels and/or bladder)	<input type="checkbox"/>	Occasional incontinence (less than once per day)
	<input type="checkbox"/>	Incontinent (no control or daily episodes of incontinence)
	Assessment notes – Personal Care/Self Care:	
Activity	Rating (✓ one)	Communication, Cognition & Behaviour
16. Communication (Need for assistance with understanding or making oneself understood by others)	<input type="checkbox"/>	No assistance required including independent use of aids and equipment such as hearing aids or speech aids. Do not indicate use of interpreters here.
	<input type="checkbox"/>	Some assistance required (e.g. if person sometimes or often misses the speaker's intent, or needs prompting to find words or finish sentences.)
	<input type="checkbox"/>	Assistance always required
Assessment notes – Communication:		
17. Memory problems or confusion	<input type="checkbox"/>	No
	<input type="checkbox"/>	Yes
18. Behavioural problems	<input type="checkbox"/>	No
	<input type="checkbox"/>	Yes (e.g. aggression, wandering or agitation)
Assessment notes – Cognition and Behaviour:		

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Assessment details

Date of assessment: dd/mm/yyyy / / Assessor Name: _____

Other comments, e.g. assessment tools used, location of assessment, other assessment summaries attached: _____
