

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

Do not write in the shaded areas. Tick where appropriate.

Do not write in the shaded areas. Ink where appropriate.

SECTION A REGISTRATION DETAILS

A. ORGANISATION:				Registration No:		Date of registration:	
				Assessment completed on:		Date of admission:	
Date of notification:		Urgency:		Place of Assessment:			
Type of Assessment:							
New notification		Within 24 hours		Own dwelling		Hospital	
Revision		Within 1 week		Home for 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'S PERSONAL DETAILS:							
Surname:				Marital Status:			
Full name:							
First name and initials:							
Address:							
Tel No:							
Date of birth/Age: (ID Number)		Gender:		M	F	Other	
Race: (for statistical purposes)		ACCOMMODATION:		FAMILY COMPOSITION:			
		Owner		Lives in old age home			
		Tenant		Lives alone			
		House		With spouse			
		Flat		With children/child			
		Retirement complex		With other family			
		Private home/guest house/ hotel		With other elderly			
		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					
SOURCE OF INCOME:		GROSS INCOME PER MONTH:					
Disability Grant	Individual	Couple	Total Monthly Income per household: R				
Old Age Pension							
War Veterans							
Other (private)							
Specify details of financial dependants:							

MEDICAL CONDITIONS / OTHER PROBLEMS									
C. NEEDS IDENTIFIED BY CLIENT					Additional information obtained from:				
					<input type="checkbox"/> Applicant him / herself <input type="checkbox"/> Caregiver <input type="checkbox"/> Family <input type="checkbox"/> Social worker <input type="checkbox"/> Medical personnel <input type="checkbox"/> Other				
D. DETAILS REGARDING NEXT OF KIN / CARE-GIVER:									
Next of kin: Relationship: Spouse /son /daughter /other Age (Optional): Address:					Next of kin: Relationship: Spouse /son /daughter /other : Age (Optional) Address:				
Telephone no: Work: Home:					Telephone no: Work: Home:				
SECTION 2: ASSESSMENT									
A. Urgent Evaluation Criteria					Medical conditions / diagnoses:				
Bed bound									
Mentally disabled with total incontinence									
Chronic high risk medical conditions requiring continuous nursing care									
B. CRITERIA FOR ADMISSION: 1. SKILLED CARE:									
a. Pressure care:					b. Specialised care:				
0 Nil needed					0 Requires no care / dressings				
11 1 to 3 x per day					11 Simple, daily treatment or dressings				
22 Every 4 hours					42 Requires complicated treatment /dressings more than 3 x per day				
33 Every 2 hours					Other specialised care required /comments:				
c. Night-care:									
0 No or infrequent night care required					Current medication:				
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: =									

2. ACTIVITIES OF DAILY LIVING (ADLs)

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. COMMUNITY INFRASTRUCTURE					
Transport	Telephone	Post Office	Not applicable (institutionalised)		
			Available		
			Limited		
			Inaccessible		
			Not available		
6. SUPPORT SYSTEMS AVAILABLE TO CLIENT					
0	Support system (spouse, family, friends) functioning well		Not applicable (institutionalised)		
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:					
0	Care-giver fully in control of the situation		Not applicable (institutionalised)		
7	Requires some support				
40	Not healthy / aged / disabled				
67	Requires continuous support / help				
67	Total incapacity to provide care				
67	Total burnout				
Section 7 score					
0	TOTAL SCORE Section 6 + 7 "Care"				

SECTION 4: RECOMMENDATION

Admission to home for the aged

If Admission Recommended

Urgent

As soon as possible

Other:

Community services

Medical services

Geriatric services

Psychiatric services

Referral for community health services

Yes

Yes

Yes

Yes

No

No

No

No

Re-assess: Date:

Date:

Community support service recommendation:

No additional support services recommended

Additional support by means of certain home care services

Indicate which services are currently "in use" or "required".

Required

In Use

Day care (at home)

Meals-on-wheels

Home help

Bed bath (personal care)

Frail care (institutional)

Hospital care

Day Care (Centre)

Respite care (relief)

Nursing services

Social work care

Other

Centre programmes (clubs)

Required

In Use

Occupational therapist

Physiotherapist

After-care rehabilitation

Garden service

Assisted living

Support group

Required

In Use

SECTION 5: CONCLUSION OF ASSESSMENT

Assessor:

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

Signature:

Date:

Applicant / Caregiver:

I have discussed the assessment, recommendations and appeal procedure 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:

Signature:

Date:

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 6: KEY TO ASSESSMENT FOR SERVICE REQUIREMENT				FINDINGS:		
Score from "Skilled" (Section 1)	0	0.2	0	Requires institutional care	Yes	No
Score from "ADLs" (Section 2)	0	0.25	0	If Yes, Specify care type required:		
Score from "Mental" (Section 3)	0	1	0	Temporary		Permanent
Score from "Primary" (Section 4)	0	0.15	0	Respite (care-giver relief)		Terminal
Total score "Caret" (Section 6 & 7)	0	0.15	0	Rehabilitation		
DQ98 INDEX SCORE		Total	0			

Additional information :
