WATERFORD INTELLECTUAL DISABILITY ASSOCIATION

Daily Living and Needs Assessment Form C4-017

Name of person: ....

Address: ....

....

Date of assessment: ....

Person carrying out the assessment: ....

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1. Carer and family involvement and other social contacts and relationships

Next of kin	**Other contact/relationship**
Name: .... Relationship: .... Address:... .... Tel: (day) .... (night) .... In event of illness contact at night? YES/NO	Name: .... Relationship: .... Address: .... Tel: (day) .... (night) .... In event of illness contact at night? YES/NO
Other contact/relationship	**Other contact/relationship**
Name: .... Relationship: .... Address:... .... Tel: (day) .... (night) .... In event of illness contact at night? YES/NO	Name: .... Relationship: .... Address: .... Tel: (day) .... (night) .... In event of illness contact at night? YES/NO

All personal records are confidential

NB See list of approved visitors e.g. guardship where applicable.

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2. Personal care and physical well-being

Assessed Needs to be covered by the Service User's Assessment / Care Plan, please tick box.

Personal care and Physical well-being		Communication		Mobility and Dexterity		Personal Safety and risk assessment	
Medical history		Medication		Mental health and cognition		Diet and weight	
Food and meal times		Dental and Foot care		Religious observance		Daily living and social activities	

2.1 Personal care and physical well-being			
2.1.1 Is the person being assessed able to perform any of the following <u>unaided</u>? *Circle as appropriate*			
Wash	YES / NO	Dress	YES / NO
Step into a bath	YES / NO	Apply make-up	YES / NO
Put shoes on	YES / NO	Go to the toilet	YES / NO
Get up in the morning	YES / NO	Go to bed at night	YES / NO
Make a light meal	YES / NO	Make a cup of tea	YES / NO
Light housework	YES / NO	Other?	
2.1.2 Please give a written indication of your perception of the person's ability to care for themselves in addition to the above. For any of the areas circled NO, please complete the appropriate section in the following pages of this Needs Assessment form.			

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Where the assessment identifies that support is required, the relevant section below must be completed.

2.2	Communication	
2.2.1	Does the person use spectacles or hearing aids? Please specify:	YES / NO
2.2.2	Is the person registered as blind?	YES / NO
2.2.3	Is the person being assessed able to hold a conversation? Please indicate reasons why conversation or understanding might be impaired e.g. sensory, cognitive or physical impairment.	YES / NO
2.2.4	Are there any aids required to assist with communication? If yes, please specify e.g. loop, picture boards, writing pad, sign language, finger signing, graphics, symbols, communication dictionary, etc.	YES / NO
2.3	**Mobility and dexterity**	
2.3.1	Does the person have any problem with mobility? If yes, please specify and also record any mobility aids used.	YES / NO

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2.4	Personal safety and risk assessment	
2.4.1	Please provide from the service user's history any concerns about personal safety and risk including history of falls. Describe your perception of the person's mobility.	
2.5	**Medical history**	
2.5.1	Please specify as much detail as possible of the person's medical history.	
2.5.2	Has a medical report been obtained from GP?	YES / NO
2.5.3	Does the person require assistance to manage continence? If yes, please specify.	YES / NO

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2.6 Medication

2.6.1 Does the person currently take medication? YES / NO
Please provide a full list with strengths, frequencies, dosage etc.

Medication	Frequency of dosage	Dosage

2.6.2 Does the person wish to self-medicate? YES / NO

2.6.3 Does the person experience difficulties with self-medication? YES / NO
If yes, please specify.

2.7 Mental health and cognition

2.7.1 Does the person have any problems with mental health? YES / NO
If yes please specify.

2.7.2 Does the person have any problems with cognition? YES / NO

2.8 Diet and weight

2.8.1 Does the person have any problems with their diet? YES / NO
Does the person have any problems with their weight? YES / NO
If yes, please specify.

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2.8	**Diet and weight** (*Continued)*	
2.8.2	Does the person have any dietary preferences or special dietary requirements? If yes, please specify.	YES / NO
2.9	**Food and meal times**	
2.9.1	Does the person require assistance with eating?	YES / NO
2.9.2	What are the person's preferred meal times and likes and dislikes of food? Please specify.	
2.10	**Dental and foot care**	
2.10.1	Does the person require assistance with dental care? Does the person require assistance with foot care? If yes, please specify e.g. if dentures used, person's use of dentist and chiropodist.	YES / NO YES / NO
2.11	**Religious observance**	
2.11.1	Does the person require assistance with practising their religion? If yes, please specify.	YES / NO

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2.12	Daily living and social activities
2.12.1	What kind of social interests and activities is the person interested in? Please specify, and level of assistance required.

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