sunnyside house

130 High Street, Aveley, South Ockendon, Essex, RM15 4BX
Tel/Fax: 020 8592 2266 ● www.sunnysidehouse.net ● care@expresshomes.co.uk

ASSESSMENT FORM

SERVICE USER DETAILS: Section 1

Full Name……………………………………………….

Address……………………………………………………………………………………
…………………………………………………………………………………………….

Telephone Number………………………………………
Mobile Number………………………………………….

Clinical Diagnosis………………………………………………………………………
……………………………………………………………………………………………..

Details of G.P Name, Surgery and Contact Number
……………………………………………………………………………………………
…………………………………………………………………………………………….

Date of Birth…………………………………….

Age…………..

Gender: Male Female

Ethnic Origin…………………………………….

Marital Status: Single Married Divorced Widow

Religion……………………………………………

Dependents…………………………………………………………………………….

Next Of Kin……………………….
Address………………………………………………………………………………
Contact Number……………………………

Friends……………………………………………………………………………..
……………………………………………………………………………………………..

Advocate…………………………………………………………………………………
……………………………………………………………………………………………...

Criminal Convictions? Yes No
If yes Please state conviction…………………………………………………………

REFERRAL DETAILS: Section 2

Date referred to Sunnyside…………………………………………….
Agency…………………………………………………………………
Telephone Number……………………………………………………..

Date the Service user was informed of referral……………………………………
Date allocation was made………………………………………………
Date key worker made contact with Service User……………………………

Date of assessment…………………………………………………….

Assessment completed by:

Name	Position	Signature
1.		
2.		
3.		

Name of allocated key worker…………………………………………….

Do you agree to give me/us at Sunnyside House, information about yourself to help me/us plan your care if appropriate?: Yes No

Type of accommodation and whom the service user lives with and what are their role?
………………………………………………………………………………………
………………………………………………………………………………………
………………………………………………………………………………………
……………………………………………………………………………………….

Languages:
1st Language…………………………………………
2nd Language…………………………………………
Other (Please specify)…………………………….

Cultural needs: including religion, gender specific, diet, and worship practices.
……………………………………………………………………………………..
……………………………………………………………………………………..
……………………………………………………………………………………..
……………………………………………………………………………………..
……………………………………………………………………………………..

Funding Borough/Health Authority……………………………………………..

Summary: Please specify reasons for referral
…………………………………………………………………………………………
…………………………………………………………………………………………
…………………………………………………………………………………………
……………………………………………………………………………………..

Significant others in Service users' life for all needs (e.g. Physiotherapy, occupational therapist)
Name(s)…………………………………………………………………..
Designation………………………………………………………………….
Involvement…………………………………………………………………
Contact Number(s)………………………………………………………….

Background/Circumstances:
Homes, Life events, education, evidence of learning difficulty and what the service users are saying that his/her needs are.
………………………………………………………………………………………..
………………………………………………………………………………………..
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Home Environment:
Outcome of key worker assessment
………………………………………………………………………………………
………………………………………………………………………………………
………………………………………………………………………………………
………………………………………………………………………………………
………………………………………………………………………………………
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Communication Skills:
………………………………………………………………………………………
………………………………………………………………………………………
………………………………………………………………………………………
………………………………………………………………………………………
……………………………………………………………………………………….
………………………………………………………………………………………
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Relationships:
………………………………………………………………………………………
………………………………………………………………………………………
………………………………………………………………………………………
………………………………………………………………………………………
………………………………………………………………………………………
………………………………………………………………………………………

DOMESTIC SKILLS & INVOLVEMENT: Section 3

Tasks	Independent with aids	Independent without aids	Partially supported	Fully supported	Frequency
Preparing a meal					
Shopping (Food)					
Budgeting					
Cleaning					
Shopping (Personal care)					
Laundry					
Participation in activities					
Handling Hot beverages					
Other Please Specify					

PERSONAL SKILLS & INVOLVEMENT: Section 4

Tasks	Independent with aids	Independent without aids	Partially supported	Fully supported	Frequency
Walking					
Eating & Drinking					
Mouth care					
Hair care					
Skin care					
Bath & Shower					
Shaving					
Toileting					
Sleeping					

Roles and interests, employment, educational needs/wishes, aspirations: Section 5

Employment opportunities:
………………………………………………………………………………………
………………………………………………………………………………………
………………………………………………………………………………………

What would you like to do in the future?
………………………………………………………………………………………
………………………………………………………………………………………
………………………………………………………………………………………..

Personal development/Aspirations
………………………………………………………………………………………
………………………………………………………………………………………
………………………………………………………………………………………

What would you like to achieve now?
………………………………………………………………………………………
………………………………………………………………………………………
………………………………………………………………………………………

What would you like to achieve later on?
………………………………………………………………………………………
………………………………………………………………………………………
……………………………………………………………………………………….

Weekly Routines

Monday
AM……………………...PM……………………………Events……………………

Tuesday
AM………………………PM……………………………Events…………………….

Wednesday
AM………………………PM……………………………Events……………………

Thursday
AM………………………PM……………………………Events……………………

Friday
AM………………………PM……………………………Events……………………

Saturday
AM………………………PM……………………………Events……………………

Sunday
AM………………………PM……………………………Events……………………

Details of benefits and Finance
…………………………………………………………………………………………
…………………………………………………………………………………………
…………………………………………………………………………………………

Community Participation:

Please give details of any income the service user is receiving:				
Income Support	**Sickness Benefit**	**Invalidity Benefit**	**Incapacity Benefit**	**Other**

How do you access community services?
…………………………………………………………………………………………
…………………………………………………………………………………………
…………………………………………………………………………………………

What opportunity do you have to access community services?
…………………………………………………………………………………………
…………………………………………………………………………………………
…………………………………………………………………………………………

What support do you need?
…………………………………………………………………………………………
…………………………………………………………………………………………
…………………………………………………………………………………………

Behaviours that challenge others (Please list behaviours currently of concern in order of severity)
…………………………………………………………………………………………
…………………………………………………………………………………………
…………………………………………………………………………………………
…………………………………………………………………………………………

Describe action what are they doing? (Please Tick where appropriate)

1. Needs were expressed in a challenging way but did not constitute any risk to self/ or others/or to future opportunities

2. Behaviours resulted in service user being prevented from continuing with activity/ session

3. Behaviours occur infrequently i.e. once per year

4. Has potential for causing psychological Distress to self to self or others

5. Minor damage to public or personal property

6. Frequent damage to public/ personal property

7. Behaviours are continuing for lengthy periods of time, causing severe distress to self/carers but placement not at risk

8. Behaviours resulting in loss of access to community or services i.e. potential risk of placement crisis/breakdown

9. Potential risk of physical harm to self or to others i.e. threat to injure self or others

10. Severe risk to self or others, from physical harm

    i.e. physical injury can occur, placement in crisis/ breakdown imminent

HEALTH ASSESSMENT: Section 6

Your Health:
Do you have any of the following?

Heart Problems Yes No

Diabetes Yes No

Hypertension Yes No

Sickle cell disorders Yes No

Asthma Yes No

Hay fever Yes No

Allergies Yes No

Cancer Yes No

Epilepsy Yes No

Mental Health Problems Yes No

(If yes please specify diagnosis)
………………………………………………………………………………………..

Other illness(s) or disorders? Yes No

(Please specify)
……………………………………………………………………………………..

Vision:
Please tick where appropriate

No problem

Partially sighted with aid

Partially sighted without aid

Blind with/without aid

Hearing:
Please tick where appropriate

No problem

Partially hearing with aid

Partially hearing no aid

Deaf with/without aids

Ear defects accident

Continence:
Elimination-
Do you need a continence assessment? Yes No

If yes please
comment……………………………………………………………………………
………………………………………………………………………………………

Do you have any other health problems?
Please state
………………………………………………………………………………………
………………………………………………………………………………………
………………………………………………………………………………………

Have you had any investigations done in the last 6-12 months relating to your health?
Please state
………………………………………………………………………………………
………………………………………………………………………………………
……………………………………………………………………………………..

Health checks:
When did you last have these following checks:

	3 months or less	6 months- 2 years	Over 2 years
G.P			
Dentist			
Optician			
Chiropodist			
Audiologist			
Other (Please specify)			

Health screening:
Have you ever had the following tests:

Cervical screening Yes No Date………………………..

Breast screening Yes No Date………………………..

Testicular screening Yes No Date………………………..

Any other screening (e.g., Hep B or HIV)
Please specify
……………………………………………………………………………

Health Living:

Diet/Nutrition

	Yes	No	If Yes, How often or comment?
Do you smoke?			
Do you drink alcohol?			
How fit are you?			
Do you exercise?			
Do you consider yourself to be overweight?			
Do you use alternative therapy/ homeopathic medicine?			
Do you use illicit drugs/ substances?			
Do you take any medication?			

Medications:

Details of Medication	Form (Suspension, tablet injection etc)	Dosage	Last review date

Compliance:

	Yes	No	Comment
Self medicating			
With some support			
With full support			
Other (Please specify)			

Allergies:
Any known allergies to medication please state?
…………………………………………………………………………………………
…………………………………………………………………………………………
…………………………………………………………………………………………

MENTAL HEALTH: Section 7

Is there any Mental Health issue?

Yes No

If 'Yes' please state………………………………………………………………………..

Section under the Mental Health Act:…………………………………………………..

RISK ASSESSMENT: Section 8

Type of Risk
……………………………………………………………………………………………
……………………………………………………………………………………………

Risk context and action recommendations
……………………………………………………………………………………………
……………………………………………………………………………………………
……………………………………………………………………………………………
……………………………………………………………………………………………

Self neglect:

Hygiene
……………………………………………………………………………………………
……………………………………………………………………………………………

Finance
……………………………………………………………………………………………
…………………………………………………………………………………………….

Daily Living
……………………………………………………………………………………………
…………………………………………………………………………………………….

Self Harm: To include specific threats, substance abuse, suicidal tendencies
……………………………………………………………………………………………
……………………………………………………………………………………………
……………………………………………………………………………………………

Exploitation: By others, physical, emotional, sexual and financial
……………………………………………………………………………………………
……………………………………………………………………………………………
…………………………………………………………………………………………….

Vulnerability:
……………………………………………………………………………………………
……………………………………………………………………………………………
……………………………………………………………………………………………

Risk to others: To include disruptions, violence and fear
……………………………………………………………………………………………
……………………………………………………………………………………………
……………………………………………………………………………………………

SUMMARY OF VIEWS EXPRESSED: Section 9

Service user:
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Key worker:
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Professional/Staff:
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QUALITY ASSESSMENT: Section 10

Please leave this section with the service users and ask them to fill it in and return with stamped address envelope.

Please take time in answering these questions:

1. Were you listened to and treated with respect? Yes No

Please Comment
…………………………………………………………………………………………
…………………………………………………………………………………………

2. Did you feel that you was part of this assessment? Yes No

Please Comment
…………………………………………………………………………………………
…………………………………………………………………………………………

3. Did you talk to all the people involved in your care? Yes No

Please Comment
…………………………………………………………………………………………
…………………………………………………………………………………………

4. What can we do to make the assessment better?
…………………………………………………………………………………………
…………………………………………………………………………………………
…………………………………………………………………………………………
…………………………………………………………………………………………
…………………………………………………………………………………………

Signature……………………

Your Name………………….

Date………………………….