Supported Accommodation Service
Resident's Assessment Form

(for completion by the resident's doctor, and review every 6 months, see Form 2A)

Form 2
Schedule to Form 1
Resident's Details

Resident's Name: _____

Date of Birth: _____ Gender: Male / Female

Supported Residential Service: Palmville Group Homes Pty Ltd
PO BOX 503
BOOVAL QLD 4304

Tick the column which describes the resident's needs in each area

Activity	No Assistance Required	Individual Prompting & Supervision	Physical Assistance Required	Details / Comments

1 Health Needs

Cognition & Perception

* orientation	☐	☐	☐	
* memory	☐	☐	☐	
* wandering	☐	☐	☐	
* personal safety *(use household appliances / emergency response / stranger treatment)*	☐	☐	☐	

Health Issues

* taking medication	☐	☐	☐	
* other regular health needs *(diabetics, wound dressings, nebuliser, epilepsy)*	☐	☐	☐	
* personal injury *(ability to attend to minor first aid and/or seek assistance)*	☐	☐	☐	
* medical *(ability to recognise need for medical intervention and initiate assistance)*	☐	☐	☐	

Night Support

* safe practices *(turning off appliances, lock premises, emergency responses)*	☐	☐	☐	
* sleeping patterns *(go to bed sleep through night)*	☐	☐	☐	
* physical supports *(continence etc)*	☐	☐	☐	
* behavioural issues *(requires staff prompting supervision to limit impact)*	☐	☐	☐	

Behaviour Support	(Pls Circle)	Comments
* behaviour issues	yes / no	
* absconding/wandering	yes / no	
* aggressive towards others	yes / no	
* self injury	yes / no	
* physically assaultive towards others	yes / no	

* other behavioural issues
(describe)

_____

_____

_____

date: July 2000
produced by: HIDU and SAPA

Activity	No Assistance Required	Individual Prompting & Supervision	Physical Assistance Required	Details / Comments

2 Daily Living Activities *(2.1 of Quality of Care Principles of 1997)*

Personal Hygiene

* bathing / showering				
* grooming				
* personal hygiene *(teeth cleaning, shaving)*				

Continence

* managing continence				
* toileting				
* continence aids				

Eating

* eating				
* eating aids				

Dressing

* dressing				
* undressing				
* dressing aids				

Mobility

* ambulation *(walking)*				
* transfers *(moving between sitting / standing / lying)*				
* negotiating stairs				
* mobility aids *(wheelchair / frame / cane)*				
* use of safety devices *(eg: handrails)*				
* use of transport				

Communication

	Pls Circle Appropriate Assessment				
* speech	coherent	slurred	aphastic	communication aid	requires assistance to maintain aids
* hearing	no loss	aid	deafness	requires assistance to maintain aids	
* eyesight	good	glasses	failing	blind	requires assistance to maintain aids
* recognition	family	friends	unresponsive		

	No Assistance Required	Individual Prompting &	Physical Assistance	Details / Comments
* general communication needs *(ability to express concepts and needs)*				
* use of telephone				
* reading				
* writing				

	(Pls Circle)	Comments

3 NURSING SERVICES *(3.8 of Quality of Care Principles 997)*

* assessment and planning of care by Registered Nurse	yes / no	
* management of care carried out by Registered Nurse	yes / no	
* nursing services *(eg: pain management, wound management, etc)*	yes / no	

4 Other Comments / Medical Issues

5 Paramedical Needs *(eg speech pathologist, physiotherpist, etc)*

I certify that this resident requires continiuous assistance with above assessed care services .	signed name provider nos. date

(Note to meet the requirements for services to be GST free, a resident must be assessed as needing, on a continuous basis, either physical assistance or supervision / prompting with <u>one</u> of the services listed under daily living activities (2) or nursing services (3).

Supported Accommodation Service
Resident's Assessment Form

Form 2A
Schedule to Form 1
Update Schedule

Review Date	Changes to Previous Assessment in Form 2	Medical Practitioner's signature