Reflections

Service User Needs Assessment

Personal Information	
Full Name:	
Preferred Name:	
Address:	
Telephone No:	
D.O.B:	
G.P Details:	
C.P.N Details:	
Consultant Details:	
Other Professionals:	
Next of Kin Information	
Full Name:	
Relationship:	
Address:	
Telephone No:	
Main Carers Information	
Full Name:	
Address:	
Telephone No:	
Carers Overall Health:	
Carers Assessment (DACS):	
Date Completed:	
Legal Matters	
Benefits Checked:	
Office Public Guardian/Legal Status:	

Preliminary Assessment	
Use of stairs:	
Escort needed for transport:	
Help In/Out of car:	
Care package at home:	
Wears lifeline:	
Assistive technology used at home:	
Comfort aids:	
Habits/Rituals:	
Behavioural triggers:	
History of falls:	
Additional Information:	

Mental State/Attitude	
Comprehension:	
Orientation:	
Memory:	
Wandering:	
Frustrations:	
Depression:	
Learning Difficulties:	
Additional Information:	

Communication Needs

Sight			
Good		Spectacles	
Partial		Contact Lenses	
Blindness		Last Eye Test	
Hearing			
Good		Hearing Aids	
Partial		Which Ears	
Deafness		Last Hearing Test	
Speech			
Good		Dentures Worn	
Poor		Last Dental Check	
None			
Input by speech therapist:			
Other ways of communication:			
Continence			
Can use toilet alone		Incontinent	
Needs a little assistance		Urinary	
Needs a lot of assistance		Faecal	
Pads Worn		Catheterized	
Mobility			
Assistance needed with mobility:			
Mobility aids used:			
Suitable footwear		Last chiropody check	
Additional Information:			

Food and Eating			
Special dietary needs:			
Can prepare own food:			
Needs assistance with eating:		**Needs assistance cutting food:**	
Good appetite:		**Small appetite:**	
Food/drink likes:			
Food/drink dislikes:			
Additional Information:			

General and Social Information	
Family (children, grandchildren etc):	
Church/ Social Groups/Friends:	
Significant Life Events:	
Past Jobs:	
Sleep Pattern:	
Allergies to Pets:	
Favorite Music/Films/Reading:	
Activities Likes:	
Activities Dislikes:	

Additional Information:	

Current Medical Conditions	
Diagnosis:	
Date of Diagnosis:	
Type:	
Awareness of Diagnosis:	
Current Medication:	
Last Medication Review:	
Allergies:	
General State of Health:	

Further Medical History					
Eating Disorders		**Alcohol**		**Diabetes**	
Smoking + no per day		**Epilepsy**		**Heart Problems**	
Breathing Problems		**Blood Pressure**		**UTI's/ Constipation**	

Additional Information:	

Days Preferred to attend						
Saturday	**Sunday**	**Monday**	**Tuesday**	**Wednesday**	**Thursday**	**Friday**

Initial Visit Booked:	
Funded By:	
Input Sent to Accounts:	
Additional Information:	