|  |  |
| --- | --- |
| Name of Person Using the Service:  DOB:  Establishment Address: | Place of Assessment:  Height:  Weight:  State if: |

With the person using the service, please consider by ticking and commenting, where appropriate if any of the following factors need to be taken into account, when assistance to move is required. Refer to Care Plan for further information

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Assessment No:** | | | **Fully Independent Yes**  **No** | | | |
| 1.Communication  2.Comprehension  3.Sight/hearing  4.Appropriate behaviour  5.History of falls/seizures  6.Medication | | 7.Sitting balance  8.Sitting to stand  9.Weight bearing  10.Walking  11.Upper limb strength  12.Head control | | | 13.Range of joint movement  14.Muscle power/tone  15.Involuntary movement  16.Supports attachments  17.Pain  18.Skin condition  19.Other | |
| Comments: **People involved in the assessment:** | | | | | | |
| Assessors Name |  | | | Assessors Designation | |  |
| Assessors Signature |  | | | Date of Assessment | |  |

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| --- | --- | --- |
| Name of Person Using the Service: | | |
| Assessment Criteria: | Assessment No: | |
|  | Date: | |
| SIT/STAND | Not applicable | |
| * Independent? | Yes | No |
| * + No. Carers | 1 2 3 4 | |
| * Equipment |  | |
| * + Method |  | |
| * + Variance | Yes  No | |
| SIT/SIT | Not applicable | |
| * Independent? | Yes | No |
| * + No. Carers | 1 2 3 4 | |
| * Equipment |  | |
| * + Method |  | |
| * + Variance | Yes  No | |
| ASSISTANCE TO USE THE TOILET | Not applicable | |
| * Independent? | Yes | No |
| * + No. Carers | 1 2 3 4 | |
| * Equipment |  | |
| * + Method |  | |
| * + Variance | Yes  No | |
| WALKING | Not applicable | |
| * Independent? | Yes | No |
| * + No. Carers | 1 2 3 4 | |
| * + Equipment |  | |
| * + Method |  | |
| * + Variance | Yes  No | |
| MOVING UP/DOWN BED | Not applicable | |
| * Independent? | Yes | No |
| * + No. Carers | 1 2 3 4 | |
| * Equipment |  | |
| * + Method |  | |
| * + Variance | Yes  No | |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| TURNING IN BED | Not applicable | | | |
| * Independent? | Yes | | No | |
| * + No. Carers | 1 2 3 4 | | | |
| * + Equipment |  | | | |
| * + Method |  | | | |
| * + Variance | Yes  No | | | |
| IN/OUT BED | Not applicable | | | |
| * Independent? | Yes | No | | |
| * + No. Carers | 1 2 3 4 | | | |
| * + Equipment |  | | | |
| * + Method |  | | | |
| * + Variance | Yes  No | | | |
| BATHING/SHOWERING | Not applicable | | | |
| * Independent? | Yes | No | | |
| * + No. Carers | 1 2 3 4 | | | |
| * + Equipment |  | | | |
| * + Method |  | | | |
| * + Variance | Yes  No | | | |
| FIRE EVACUATION | Not applicable | | | |
| * Independent? | Yes | No | | |
| * + No. Carers | 1 2 3 4 | | | |
| * + Equipment |  | | | |
| * + Method | Follow PEEPS procedure | | | |
| FALLS | Not applicable | | | |
| * Independent? | Yes | | | No |
| * No. Carers | 1 2 3 4 | | | |
| * Equipment |  | | | |
| * Method |  | | | |

|  |  |  |
| --- | --- | --- |
| TASK | Not applicable | |
| * Independent? | Yes | No |
| * + No. Carers | 1 2 3 4 | |
| * + Equipment |  | |
| * + Method |  | |
| * + Variance | Yes  No | |
| TASK | Not applicable | |
| * + Independent? | Yes | No |
| * + No. Carers | 1 2 3 4 | |
| * + Equipment |  | |
| * + Method |  | |
| * + Variance | Yes  No | |
| TASK | Not applicable | |
| * + Independent? | Yes | No |
| * + No. Carers | 1 2 3 4 | |
| * + Equipment |  | |
| * + Method |  | |
| * + Variance | Yes  No | |

|  |  |  |  |  |
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| **HOIST DETAILS** | | | | |
| HOIST  DETAILS | Make |  | | |
|  | Model |  | | |
|  | Type  (Tick) | Mobile | | Fixed |
|  |  | Standing | | Gantry |
| SLING DETAILS | Type | Explain loop or clip arrangement: | | |
|  | Size e.g. S, M, L, XL, XXL | |  | |
| **HOIST DETAILS** | | | | |
| HOIST  DETAILS | Make |  | | |
|  | Model |  | | |
|  | Type  (Tick) | Mobile | | Fixed |
|  |  | Standing | | Gantry |
| SLING DETAILS | Type | Explain loop or clip arrangement: | | |
|  | Size e.g. S, M, L, XL, XXL | |  | |

|  |  |  |  |
| --- | --- | --- | --- |
| **Assessor Name** | **Designation** | **Signature** | **Date** |
|  |  |  |  |