**Assessment Information**

**This assessment belongs to:**   
**Assessment Facilitator:**   
**The assessment was completed on:**   
**Name:**  
**NHI:**  
**Taikura Trust/NASC – General/Comprehensive Needs Assessment Form/Issued:** Oct 2016 : Version 4  
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**Client Details**

* **Last name:**
* **First name:**
* **NHI number:**
* **Title:**
* **Marital status:**
* **Gender:**
* **Address:**
* **Type of residence:**
* **Relationship to others in the household:**
* **Date of birth:**
* **Ethnicity:**
* **Preferred language:**
* **Interpreter required:**
* **Community services card:**
* **CSC expiry date:**
* **Home phone:**
* **Mobile:**
* **Email:**
* **Work phone:**
* **Preferred contact method:**
* **Name of GP:**
* **GP’s phone number:**
* **Primary disability:**
* **Interim eligibility:**

**Disability / Diagnosis Details**

**[Details]**

**Reason for Assessment / Referral to Taikura Trust**

* **Reassessment to identify ongoing disability-related need**
* **Residency status:**
* **ACC claimant:**
* **Case manager name:**

**Other Information (e.g., alternative name)**

**Any reports to share, please list them below:**

**Alternative Contact Details**

* **Last name:**
* **First name:**
* **Address:**
* **Home phone:**
* **Mobile:**
* **Email:**
* **Work phone:**
* **Relationship to client:**
* **Date of birth:**

**Emergency Contact Details**

* **Last name:**
* **First name:**
* **Address:**
* **Home phone:**
* **Mobile:**
* **Email:**
* **Work phone:**
* **Relationship to client:**
* **Date of birth:**

**Consent for Information**

**I understand that:**

* It is necessary to complete this assessment to identify my resources, abilities, goals, and disability support needs. ☒ Yes ☐ No
* I shall receive a copy of my assessment. ☒ Yes ☐ No
* I have the right to see and correct any personal information kept about me. ☒ Yes ☐ No
* The supply of information is voluntary. ☒ Yes ☐ No
* If I do not supply information, it may mean that my disability support needs will not be identified and assessed correctly, which may result in the support services I need not being made available. ☒ Yes ☐ No
* This assessment does not decide if I am eligible for government home-based support or residential care. ☒ Yes ☐ No

**I consent to:**

* Taikura Trust using this information to help support my disability support needs (through service coordination). ☒ Yes ☐ No
* Taikura Trust accessing my medical reports which clarify my disability and/or my health concerns. ☒ Yes ☐ No
* Relevant information from my assessment being shared with MOH, Health Professionals and/or my Service Provider to support my safety and well-being. ☒ Yes ☐ No
* My assessment being stored by Taikura Trust. ☒ Yes ☐ No

**Those Present / Those Consulted**

* **[Consulted]**

**Needs Assessment**

* **Assessment type:**
* **First contact date:**
* **Assessment completed date:**
* **Start time:**
* **Assessment location:**
* **If other, please state:**
* **Assessment outcome:**

**Background, Present Living Situation, Significant Events, and Contingency Plan**

**Current Support Networks**

**Formal (include MOH & Govt. funded):**

* GP - Doctor
* Explore – (didn’t work)
* School – Northside School

**Informal (non-paid networks):**

**Communication**

**Ability to express core needs:** ☒ Non-verbal ☒  
**Communication aids – gestures, signs, computer:** ☒ Read, write, able to use phone ☒  
**Receptive / expressive skills:** ☒ Uses visual ☒

**Narrative:**  
John is non-verbal. A high level of interpretation is needed to understand what John wants. He can say a few words, such as ‘yes’ and ‘no,’ but often relies on gestures. His family often needs to observe his behavior to determine his needs.

**Sensory / Speech Difficulties**

* **Blind or nearly blind:** ☐
* **Deaf or nearly deaf:** ☐
* **Hearing impaired:** ☐
* **Speech impaired:** ☒
* **Vision impaired:** ☐

**Narrative:**  
No concerns with his hearing and vision. John is sensitive to loud noises and prefers firm pressure. He enjoys tactile stimulation and will often engage in repetitive behaviors such as tapping or banging objects.

**Mobility / Agility / Dexterity**

* **Driving:** ☐
* **Falling / history of falling:** ☐
* **Getting up after a fall:** ☐
* **Moving around in the community:** ☒
* **Moving around inside home:** ☐
* **Moving around outside home:** ☐
* **Transfers, e.g., wheelchair to car; bed to chair:** ☐
* **Two to one assistance for all transfers:** ☐
* **Using arms, hands, or fingers:** ☐
* **Using transport as a passenger:** ☒
* **Wheelchair user (inside / outside of home):** ☐

**Narrative:**  
John is very active and constantly on the move. His behavior in the car has improved, but the family continues to use child locks for safety. He enjoys riding the bus to school but often wanders off when in the community.

**Household Management (Adult Clients Only)**

* **Faecal smearing:** ☐
* **Administering personal finances, e.g., banking or paying bills:** ☐
* **Garden / lawns:** ☐
* **Home safety, e.g., locking doors, safe appliance use:** ☐
* **Laundry:** ☐
* **Operating home heating appliances, fireplace, etc.:** ☐
* **Meal preparation:** ☐
* **Shopping for necessary items, e.g., groceries:** ☐
* **Other housework, e.g., cleaning, tidying, vacuuming, dishes, rubbish disposal:** ☐

**Narrative:**  
John does not participate in household management activities.

**Self-care / Personal Care**

* **Bathing, showering, washing self:** ☒
* **Bed mobility, e.g., rolling over, getting out:** ☐
* **Dressing and / or undressing:** ☒
* **Eating and drinking:** ☒
* **Faecal smearing:** ☐
* **Grooming and caring for body parts, e.g., feet, teeth, hair, nails:** ☒
* **Managing / preventing health problems:** ☒
* **Managing medication:** ☒
* **Menstrual management:** ☐
* **Night Care – turning / changing positions:** ☐
* **Night settling:** ☒
* **Toileting, using toilet facilities:** ☒

**Narrative:**  
John requires assistance with most personal care tasks, including showering, dressing, and toileting. He is prone to spending excessive time in the shower and requires supervision. His sleep is irregular, and he often wakes up during the night.

**Continence**

* **Faecal continence:** ☐
* **Urinary continence:** ☐

**Narrative:**  
John may have occasional accidents, especially at night.

**Behaviour**

* **Harm to others:** ☐
* **Mood and emotion, e.g., anxiety, depression, unstable mood:** ☐
* **Motivation:** ☐
* **Property damage:** ☒
* **Repetitive:** ☒
* **Routine:** ☒
* **Self-harming:** ☐
* **Sleep and night behavior, e.g., insomnia, excessive sleep:** ☒
* **Socially inappropriate:** ☒
* **Unsafe wandering:** ☒
* **Withdrawn:** ☐

**Narrative:**  
John can become frustrated and may damage property. His behavior needs careful management, especially in public spaces.

**Memory / Cognition**

* **Attention, e.g., concentration:** ☒
* **Intellectual ability, i.e., thinking, understanding:** ☒
* **Memory:** ☐
* **Orientation, e.g., to time of day, place, person:** ☐
* **Learning ability, i.e., acquiring skills of reading, writing, language, calculating, copying, etc.:** ☒

**Narrative:**  
John has a short attention span and requires simple, repetitive instructions. His learning ability is limited but he has good visual memory.

**Supervision**

* **Daily prompts:** ☐
* **Needs 24-hour supervision:** ☒
* **Some, for safety:** ☐

**Additional information:**  
John requires 24-hour supervision to ensure his safety.

**Recreational and Social**

* **Community participation, e.g., outings, shopping, local events:** ☒
* **Cultural / spiritual support, e.g., church, Marae, local cultural groups, local iwi:** ☐
* **Educational support, e.g., RTLB, MOE-SE, Specialist Teachers:** ☐
* **Family life, e.g., social work support, Strengthening Families, Child Youth & Family:** ☐
* **Meaningful day activity:** ☐
* **Recreational activities, e.g., sports clubs, craft groups, youth groups:** ☐
* **Socialisation, e.g., with peers, friends, family:** ☐
* **Vocational support, e.g., WINZ, Community Employment Trusts, Workbridge:** ☐

**Narrative:**  
John enjoys simple activities like going in and out of the spa pool. His mother avoids taking him to busy places due to his tendency to wander off and interact inappropriately with strangers.

**Goals, Hopes, and Dreams**

* **Goal / Dream:** For John to develop more communication skills so that he can express what he wants.
* **Status:** In progress
* **Goal / Dream:** For John to be content and happy.
* **Status:** In progress

**Carer Information**

**I understand that:**

* Failure to supply information requested in this form may result in support needs not being identified or fully identified with a consequent effect on any government-funded assistance while may be available to meet those needs. ☒ Yes ☐ No
* I have the right to access and correct any information collected pursuant to the Health Information Privacy Code 1994 made under the Privacy Act 1993 by contacting the Ministry of Health, PO Box 5013, Wellington. ☒ Yes ☐ No

**I consent to:**

* Information being collected, stored, and used for the purpose of identifying support needs and for service coordination in that regard. ☒ Yes ☐ No
* Information being collected for those purposes, including accessing relevant information held by other agencies (please specify). ☒ Yes ☐ No
* Information being disclosed only to the parties involved in assessment of support needs and service coordination. ☒ Yes ☐ No

**Carer Details**

* **Last name:** Smith
* **First name:** Jane
* **Address:** Same as client
* **Relationship to client:** Mother
* **Date of birth:** 15/11/1963

**Describe your health and wellbeing:**  
Jane expressed that she is managing well but is often tired due to John’s irregular sleep patterns. She is focused on planning for John’s future and is looking into residential care options.

**Identified Needs**

* **Client priority:** For the family to have more consistent and regular breaks
* **Need:** Taikura Trust
* **Client priority:** For the family to start moving John into residential care once he turns 21
* **Need:** Taikura Trust

**Completing the Assessment**

**Disabled person / representative**  
I have read and discussed this assessment (and the appeal procedure) with the assessment facilitator. I understand the nature and effect of this assessment, including that the assessment will be used to provide for my disability-related needs, and may be used to determine whether I will receive government-funded assistance in respect to my disability and also the extent I will have to pay for my own needs, and freely consent to this service being provided. ☒ Yes ☐ No  
**X Verbal consent given Date:** 15/10/2023  
**Disabled person’s / representative’s signature**

**Completing the Assessment**

**Assessment Facilitator**  
I have discussed this assessment, the identified needs, and appeal procedure with the disabled person / representative. ☒ Yes ☐ No  
**X Date:** Verbal consent given  
**Assessment facilitator’s signature**  
**Needs assessment completion time:** 10:30 AM

**Copy of Assessment**

**How would you like to receive the final copy of your assessment?**

* **Correspondence to:** Jane Smith
* **By Post:** ☐ Yes ☒ No
* **Address**
* **By Email:** ☒ Yes ☐ No
* **Email address:** jane.smith@example.com

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