**my assessment…**

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **This assessment belongs to:** | | | | **This assessment belongs to** | | | | | | |
| **Assessment Facilitator:** | | | | **Assessment Facilitator:** | | | | | | |
| **The assessment was completed on:** | | | | **The assessment was completed on:** | | | | | | |
| **client details** | | | | | | | | | | |
| Last name | Last name | | First name | | | First name | | NHI number | | NHI number |
| Title | Title | | Marital status | | | Marital status | | Gender | | Gender |
| Address | Address | | | | | | | | | |
| Type of residence | | | | | Type of residence | | | | | |
| Relationship to others in the household | | | | | Relationship to others in the household | | | | | |
| Date of birth | | Date of birth | | | Ethnicity | | | | Ethnicity | |
| Preferred language | | Preferred language | | | Interpreter required | | | | Interpreter required | |
| Community services card | | Community services card | | | CSC expiry date | | | | CSC expiry date | |
| Home phone | | Home phone | | | Mobile | | | | Mobile | |
| Email | | Email | | | Work phone | | | | Work phone | |
| Preferred contact method | | | | | Preferred contact method | | | | | |
| Name of GP | | Name of GP | | | GP’s phone number | | | | GP’s phone number | |
| Primary disability | | Primary disability | | | Interim eligibility | | | | Interim eligibility | |
| Disability / Diagnosis [details](#details" \o "Full name/diagnosis of Primary/Secondary, Medical, Mental health. Is it proven?) | | | | | | | | | | |
| Disability / Diagnosis details | | | | | | | | | | |
| Reason for assessment / referral to Taikura Trust | | | | | | | | | | |
| Reason for assessment / referral to Taikura Trust | | | | | | | | | | |
| Residency status | | Residency status | | | | | | | | |
| ACC claimant | | Residency status | | | Case manager name | | Case manager name | | | |
| Other information (e.g. alternative name) | | | | | | | | | | |
| Other information (e.g. alternative name) | | | | | | | | | | |
| Any reports to share, please list them below | | | | | | | | | | |
| 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 |  |
| Client’s [legal representative](#legal_representative" \o "Mandatory. Are they over 18yo? Is the paperwork held by us?), self, parents, CYFS, Power of Attorney, PPPR. | |  | |
| Living with parents / guardians | |  | |
| Preferred contact | |  | |

|  |  |  |
| --- | --- | --- |
| **[consent](#consent" \o "Clients Information. Read out and ensure understanding.) 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 |

|  |  |
| --- | --- |
| A person or agency I do not want to receive or supply information is (please list): |  |
| Name of person completing assessment if not the disabled person |  |
| Relationship to disabled person |  |

X Date: Click here to enter a date.

Person’s signature

|  |
| --- |
| **those** **[present](#present" \o "If client not present, reason why and if the client was sighted.) / those consulted** |
|  |

|  |  |  |  |
| --- | --- | --- | --- |
| **needs assessment** | | | |
| Assessment type |  | | |
| First contact date |  | | |
| Assessment completed date |  | Start time |  |
| Assessment location |  | | |
| If other please state |  | | |
| Assessment outcome | Requires Service Coordination | | |

|  |
| --- |
| **background, present living situation, significant events and contingency plan** |
|  |
| **current support networks** |
| **Formal (include MOH & Govt. funded):** MSD, MOE, School,Hospital, medical, SLT, OT, service providers etc. |
|  |
| **Informal (non-paid networks):**  (Family / whānau, disability support organisations (NGOs), neighbours, co-workers, spiritual support, play groups, recreational interest groups, online communities etc.) |
|  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **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:**  (e.g. Understanding language, clarity of speech etc.) | | | | | |
|  | | | | | |
| **sensory / speech difficulties** | | | | | |
| Blind or nearly blind | | |  | Deaf or nearly deaf |  |
| Hearing impaired | | |  | Speech impaired |  |
| Vision impaired | | |  |
| **Narrative:**  (e.g. Tactile etc.) | | | | | |
|  | | | | | |
| **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:** | | | | | |
|  | | | | | |
| **[household management](#household_management" \o "For under 16yo, only capture information if an exception for over age appropriate, otherwise use behavior section.) (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:** | | | | | |
|  | | | | | |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **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, etc. | |  |
| Managing / preventing health problems | |  | | Managing medication | |  |
| Menstrual management | |  | | Night Care – turning / changing positions | |  |
| Night settling | |  | | Toileting, using toilet facilities | |  |
| **Narrative:** | | | | | | |
|  | | | | | | |
| **continence** | | | | | | |
| Faecal continence | | | |  | Urinary continence |  |
| **Narrative:**  (e.g. night/day etc.) | | | | | | |
| No concerns in this area. | | | | | | |
| **behaviour** | | | | | | |
| Harm to others |  | | Mood and emotion, e.g. anxiety, depression, unstable mood | | |  |
| Motivation |  | | Property damage | | |  |
| Repetitive |  | | Routine | | |  |
| Self-harming |  | | Sleep and night behaviour, e.g. insomnia, excessive sleep | | |  |
| Socially inappropriate |  | | Unsafe wandering | | |  |
| Withdrawn |  | |
| **Narrative:** | | | | | | |
|  | | | | | | |
| **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:** | | | | | | |
|  | | | | | | |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **[supervision](#supervision" \o "Over age appropriate)** | | | | | |
| Daily prompts |  | Needs 24 hour supervision |  | Some, for safety |  |
| **Additional information:** | | | | | |
|  | | | | | |

|  |  |
| --- | --- |
| **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:**  (Activities, Barriers and Risks i.e. Social relationships: family / community roles, treasured relationships. Community recreation: community places accessed, community places you would like to access. Occupation / education: hobbies / interests etc. Cultural / spiritual: activities.) | |
|  | |

|  |  |
| --- | --- |
| **goals, hopes and dreams** | |
| Goal / Dream | Status |
|  |  |
|  |  |
|  |  |
|  |  |

|  |  |  |
| --- | --- | --- |
| **[carer](#carer" \o "Read out and ensure understanding) 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 |

X Date:

Carer’s signature

|  |  |  |  |
| --- | --- | --- | --- |
| **carer details** | | | |
| Last name |  | First name |  |
| Address |  | | |
| Relationship to client |  | [Date](#Date" \o "Mandatory) of birth |  |
| Describe your health and wellbeing: |  | | |
| Your commitments: |  | | |
| Do you have any other concerns? |  | | |

|  |  |  |
| --- | --- | --- |
| **identified needs** | | |
| Client [priority](#priority" \o "Mandatory) | [Need](#Need" \o "Mandatory) | [Who?](#Who" \o "Mandatory) |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

|  |
| --- |
| I.e. for X to be supported to explore options; to have a break, to be independent in personal cares, to manage household tasks, to understand/manage behaviours. |

|  |  |  |
| --- | --- | --- |
| **[completing](#completing" \o "Read out and ensure understanding) 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 Date:

Disabled person’s / representatives signature

|  |  |  |
| --- | --- | --- |
| **completing the assessment** | | |
| **Assessment facilitator** | | |
| I have discussed this assessment, the identified needs and appeal procedure with the disabled person / representative. | Yes | No |

Date:

Assessment facilitator’s signature Needs assessment completion time:

|  |  |  |  |
| --- | --- | --- | --- |
| **copy of** **[assessment](#assessment" \o "Send word document to adminteam@taikura.org.nz. Save as PDF and send to client and adminteam@taikura.org.nz before finishing the meeting)** | | | |
| How would you like to receive the final copy of your assessment? | | | |
| Correspondence to |  | | |
| By Post | Yes  No | Address |  |
| By Email | Yes  No | Email address |  |