OCCUPATIONAL THERAPY
INITIAL ASSESSMENT FORM

(Client details)

ASSESSMENT DETAILS

Date of Assessment:	
Referral Details: *(date, referred by)*	
Aged Care ID or DVA number:	
Home modifications CHSP code:	
Location of assessment:	
Contact number:	
People present and role: Advocate present:	☐Yes ☐ No
Consent to assessment:	☐Yes ☐No
Client reports:	

PHYSICAL STATUS

Presenting medical condition:	
Past medical history:	

Vision		Muscle weakness	
Hearing		Fatigue	
Dizziness		Joint stiffness	
Balance		Pain	
Upper limb: *(issues affecting function)*			

OCCUPATIONAL THERAPY
INITIAL ASSESSMENT FORM

Falls history:	Number of falls in the last 6 months:
Height:	Weight:

1) Have you lost weight recently without trying?

☐ No (score 0) ☐ Unsure (score 2) ☐ Yes (see below)

How many Kg? ☐ 1-5kg (score 1) ☐ 6-10kg (score 2) ☐ 11-15kg (score 3)
☐ >15kg (score 4)

2) Have you been eating poorly because of a decreased appetite?

☐ No (score 0) ☐ Yes (score 1)

Malnutrition Screening Tool (MST): Total Score:

Score of 2 or more: Refer to Dietitian ☐

Pressure Hx:

(*Complete Braden Scale Ax on Comcare DQ's if indicated*)

COGNITION AND MENTAL STATE

(alert, orientated, insight, planning, memory, problem solving, fatigue, clock drawing)

OCCUPATIONAL THERAPY
INITIAL ASSESSMENT FORM

EQUIPMENT

Current Equipment: *(purchased, hired, checked condition)*	

COMMUNITY / SOCIAL INVOLVEMENT

Living set up:	☐ Alone ☐ With spouse or partner ☐ Carer ☐ Other
Type of house:	☐ Own ☐ Housing SA ☐ Renting ☐ ECH resident ☐ House ☐ Unit ☐ Hostel ☐ RCF
Supports (formal / informal):	☐ CHSP ☐ HCP 1 ☐ HCP 2 ☐ HCP 3 ☐ HCP 4 ☐ Family ☐ Friends

OCCUPATIONAL PROFILE

I = Independent SBA = Stand By Assist A = Assisted

Self-care tasks	I	SBA	A	Comments
Showering	☐	☐	☐	
Dressing	☐	☐	☐	
Grooming	☐	☐	☐	
Toileting	☐	☐	☐	
Continence	☐	☐	☐	
Sleeping	☐	☐	☐	

OCCUPATIONAL THERAPY
INITIAL ASSESSMENT FORM

Medication management	☐	☐	☐	
Mobility *Indoor* *Outdoor*	 ☐ ☐	 ☐ ☐	 ☐ ☐	
Independent living skills	**I**	**SBA**	**A**	**Comments**
Meal preparation	☐	☐	☐	
Eating	☐	☐	☐	
Cleaning / domestic tasks	☐	☐	☐	
Laundry	☐	☐	☐	
Changing the bed	☐	☐	☐	
Shopping / Banking	☐	☐	☐	
Gardening	☐	☐	☐	
Putting bins out	☐	☐	☐	
Collecting mail	☐	☐	☐	
Driving	☐ Yes ☐ No ☐ Auto ☐ Manual			
Other transport options	☐ Taxi ☐ Family ☐ Public transport ☐ Vouchers ☐ Other			
Personal alarm	☐ Yes ☐ No ☐ Requires further information ☐ Declined further information			

OCCUPATIONAL THERAPY
INITIAL ASSESSMENT FORM

LEISURE INTERESTS, HOBBIES, WORK

HOME ENVIRONMENT

Home status:	☐ Owner ☐ Rental ☐ Public Housing ☐ ECH Resident ☐ Other	
Primary access:	Features and risks:	
	Equipment used: Recommendations: Intervention required: ☐ Yes ☐ No	
Secondary access:	Features and risks:	
	Equipment used: Recommendations: Intervention required: ☐ Yes ☐ No	
Indoor walkways:	Features and risks:	
	Equipment used: Recommendations: Intervention required: ☐ Yes ☐ No	

Stairs	Features and risks:	
	Equipment used: Recommendations: Intervention required: ☐ Yes ☐ No	
Living room/ lounge chair:	Features and risks:	
	Equipment used: Chair Transfers: Recommendations: Intervention required: ☐ Yes ☐ No	
Kitchen/ dining room:	Features and risks:	
	Equipment used: Chair Transfers: Recommendations: Intervention required: ☐ Yes ☐ No	
Bed/ bedroom:	Features and risks:	
	Equipment used: Bed Transfers: Recommendations: Intervention required: ☐ Yes ☐ No	

OCCUPATIONAL THERAPY
INITIAL ASSESSMENT FORM

Bath/ shower/ bathroom (bathroom used most frequently by client):	Features and risks:	
	Hot water system: ☐ Gravity ☐ Mains ☐ Instant Electrical safety issues: ☐ Yes ☐ No Equipment used: Transfers: Recommendations: Intervention required: ☐ Yes ☐ No	
Toilet:	Features and risks:	
	Equipment used: Toilet transfers: Recommendations: Intervention required: ☐ Yes ☐ No	
Laundry:	Features and risks:	
	Equipment used: Recommendations: Intervention required: ☐ Yes ☐ No	
Outdoor walkways/ garden area	Features and risks:	
	Equipment used: Recommendations: Intervention required: ☐ Yes ☐ No	

OCCUPATIONAL THERAPY
INITIAL ASSESSMENT FORM

Client Goals:

Further Information, Plan and Recommendations:

Therapist Name:……

Therapist Signature:…….. **Date:** / /

Occupational Therapy Recommendations

RECOMMENDATIONS	PLANNED ACTION

Any questions or concerns please call ECH on 1300 275 324.

The recommendations contained in this document have been made by the Occupational Therapist following assessment and investigation of the client's current circumstances and abilities. The above recommendations have been made by the Occupational Therapist and discussed with: _____

A copy of the above recommendations will be given to: _____
Signature: Date: