Quality of Life & Excellence

Empowering Lives Through Compassion & Expertise

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Initial Needs Assessment (INA) Form

1. Referrer Details:

- Name:
- Telephone:
- Email:
- Law Firm:

- Case Manager Details:
  Name:
  Telephone:
  Email:
  Company:
  Location of Assessment:

Date of assessment:

2. Client's Details:

- Full Name:
- Date of Birth:
- Address:
- Contact Number(s):
- Email Address:
- Guardian/Next of Kin
  - Name: _____
  - Relationship to Client: _____
  - Contact Information:

  Preferred Communication Method:

  - Phone [ ] Email [ ] Other: _____

- GP's Practice/Name:
- GP's Address:
- GP's Telephone Number:
- Consultant Specialist's details if applicable:

3. Background Information:

Incident Details
Date & Time of Injury:
Location: Indoors/Outdoors/Workplace/Public place/Private property
Cause: "Describe what happened leading up to the injury. Were there any contributing factors?"
Slipped [ ] Fell [ ] Hit by an object [ ] Motor Vehicle Accident [ ] Other: _____

- **Primary Injury:**

Injury Progression:
Has the injury worsened, improved, or remained the same since the incident?
Affected Body Areas: (see Body Map).

- **Past Medical History:** (Including pre-existing conditions exacerbated by injury):

Any pre-existing conditions:
[ ] Diabetes - Type 1[ ] Diabetes - Type 2/NIDDM [ ]
Hypertension [ ]
Arthritis [ ]

Coronary Heart Disease
MI(Heart Attack)
CABG
Peripheral Vascular Disease
Kidney Disease
Liver Disease
Asthma
COPD
Plates/Pins
Surgery - type

Other: _____

Pre-existing conditions exacerbated by the injury:
When were these conditions diagnosed?:
Severity: How do these conditions impact your daily life?:
Do you have any chronic pain? Y/N
Do you have any mobility issues?
Do you have any neurological symptoms that predate the current injury?

- **Current Medications:**

List of Medications, dosages & frequency:
Side Effects: Do you experience any side effects from your medications? Yes [ ] No [ ] Comment:
Interactions:Have you noticed any medication interactions since your injury? Yes [ ] No [ ] Comment:
Medication Clarification
Interaction with Daily Life (e.g., drowsiness, difficulty concentrating):
Integration with Treatment Goals:
Have you experienced any challenges adhering to your medication regimen due to your injury or living situation? Yes [ ] No [ ] Comment:

3a. Lifestyle Choices
Do you smoke/Vape? Yes [ ] No [ ] Comment: how many cigarettes/vapes per day?
Do you drink Alcohol? Yes [ ] No [ ] Comment: what type of alcohol? How many units per week?

4. **Mental Capacity Assessment (MCA 2005) Section:**

a)Do you feel able to make decisions about your care and treatment? Yes [ ] No [ ] Comment:
b) Do you need any aids or support to help you make decisions (e.g., interpreter, simplified materials)? Yes [ ] No [ ] Comment:

c) Has the client expressed any decisions about their care or life that require clarification or support? Yes [ ] No [ ] Comment:

d) Are the client's wishes and preferences clearly documented and considered? Yes [ ] No [ ] Comment:

E) §& & Yes [ ] No [ ] Comment:

Safeguarding:

- **Concerns:** Are there any safeguarding concerns?
  (Yes ☐ No ☐)
  if yes, give details:

5. Consent Verification:

- Confirm that consent for the INA Visit has been obtained and documented.
  Yes ☐ No ☐

6. Employment and Education History:

- **Employment Status:** Before and after injury: What was your job role and key responsibilities before the injury?

Did your job involve physical labour? If yes, describe the tasks.
Literacy and Education Level Prior to Injury:

7. Clinical Assessment

Pain Assessment

Pain Scale:

- How would you rate your pain? (0-3 scale)
  - 0: No pain
  - 1: Mild Pain (hardly any; manageable)
  - 2: Moderate Pain (noticeable but manageable)
  - 3: Severe Pain (excruciating; interferes with daily functioning)

Pictorial Scale:

- (Provide faces for 0-3 with accompanying text).

Body Map:

- Use the diagram to mark areas of pain, wounds, or other issues.
  - **Severity**:
    - Mild
    - Moderate
    - Severe

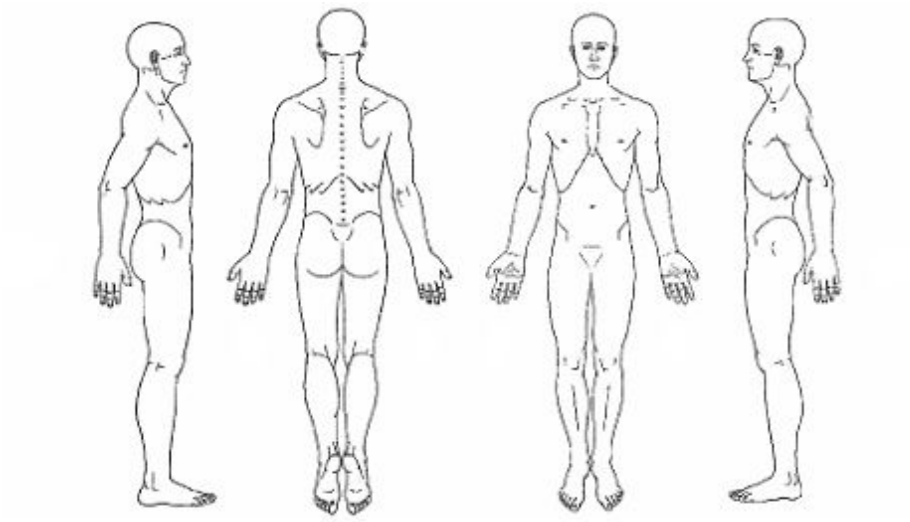
Existing wounds: (See Body Map)

- **Wounds/Abrasions**:
  - Type (e.g., bruise, cut, surgical scar): _____
  - Grading: _____
- Notes: _____
- Notes: _____

Body Map

Highlight areas on the Body map where injuries have been sustained or where there is a muscular skeletal challenge or where there is pain or all or some of the afore mentioned.

Vital Signs



- Heart Rate: _____ bpm
- Respiratory Rate: _____ breaths/min
- Oxygen Saturation: _____ %
- Temperature: _____ °C
- Pallor:
- NEWS Score:

Glasgow Coma Scale (GCS):

- **Eye Response (E)**:
  - 4: Opens spontaneously
  - 3: Opens to voice
  - 2: Opens to pain
  - 1: No response
- **Verbal Response (V)**:
  - 5: Oriented
  - 4: Confused
  - 3: Inappropriate words
  - 2: Incomprehensible sounds
  - 1: No response
- **Motor Response (M)**:
  - 6: Obeys commands

- 5: Localises pain
- 4: Withdraws from pain
- 3: Abnormal flexion (decorticate)
- 2: Abnormal extension (decerebrate)
- 1: No response

- **Total Score**: _____ / 15
- PERL: size of Pupils _____
- **Notes**: _____

Auscultation:
- Notes on chest sounds: _____

Palpation (if appropriate):
- Notes on abdominal findings: _____

Blood Sugar Levels (BM's):
- Fasting Blood Sugar: _____ mg/dL
- Post-Prandial Blood Sugar: _____ mg/dL
- Notes: _____

Dietary Patterns:
- How many meals do you eat per day? _____
- Dietary Restrictions/Preferences:
  - Vegetarian
  - Vegan
  - Gluten-Free
  - Other: _____

Urinalysis Test:
- Appearance: _____
- Protein: [ ] Positive [ ] Negative
- Glucose: [ ] Positive [ ] Negative
- Ketones: [ ] Positive [ ] Negative
- Other findings: _____

8. Physical Measurements

- Weight (kg):
- Height (cm):
- Girth Measurements (if applicable):
  - Chest: _____
  - Waist: _____
  - Hips: _____
  - Other (e.g., limb circumference): _____

- BMI: _____

9. Cognitive and Sensory Screening

Orientation:

- Time: Yes [ ] No [ ]
- Place: Yes [ ] No [ ]
- Person:Yes [ ] No [ ]
-

Memory:

- Short-term issues
- Long-term issues
- Notes: _____

Sensory Status:
Vision: Adequate [ ] Impaired [ ]

Vision:

- Do you experience difficulty reading or focusing on text? [ ] Yes [ ] No
- Do bright lights or glare bother your eyes? [ ] Yes [ ] No
- Do you find it difficult to judge distances or steps? [ ] Yes [ ] No
- Have you noticed any changes in your peripheral vision? [ ] Yes [ ] No
- **Notes**: _____

Vision Screening Prompt

- **Does the client have a history of Traumatic Brain Injury (TBI)?**
  - Yes (Consider using the Vision Screening Tool for further assessment.)
  - No
- **If yes, document findings**:
  - Observations from the Vision Screening Tool: _____
  - Referral Recommended? Yes [ ] No [ ]
  - Notes:
    _____

Hearing:

Hearing: Adequate [ ] Impaired [ ]

- Do you have trouble understanding conversations in noisy environments? [ ] Yes [ ] No
- Do you experience ringing or buzzing in your ears (tinnitus)? [ ] Yes [ ] No
- Do you feel that your hearing has diminished recently? [ ] Yes [ ] No
- **Notes**: _____

Smell:

Smell: Adequate [ ] Impaired [ ]

- Have you experienced any changes in your sense of smell? [ ] Yes [ ] No
- Do certain smells bother you more than before? [ ] Yes [ ] No
- **Notes**: _____

Taste:

Taste: [ ] Adequate [ ] Impaired

- Have you noticed any changes in your ability to taste food or drinks? [ ] Yes [ ] No
- Do certain foods or tastes seem stronger or weaker than before? [ ] Yes [ ] No
- **Notes**: _____

Touch:

Touch: Adequate [ ] Impaired Touch [ ]

- Have you noticed numbness or tingling in your hands or feet? [ ] Yes [ ] No
- Are you more or less sensitive to touch or temperature? [ ] Yes [ ] No
- Do you find it difficult to hold or manipulate small objects? [ ] Yes [ ] No
- **Notes**: _____

Next Steps/Referrals:

- Based on the above findings, is further evaluation recommended? Yes [ ] No [ ]
- If yes, specify which senses require specialist follow-up:
  - Vision (e.g., Ophthalmologist) [ ]
  - Hearing (e.g., Audiologist) [ ]
  - Touch (e.g., Neurologist/Physiotherapist) [ ]
  - Smell/Taste (e.g., ENT Specialist) [ ]
- **Notes**: _____

10. Mobility and Functional Status

Activities of Daily Living (ADLs)

- Assess current ability and required support for each area listed in the ADL section you provided earlier.

(Assess current ability and required support for each area)

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ADL Category	Independent? (Y/N)	Support Required? (Y/N)	Details of Support Needed
Maintaining a Safe Environment			
Breathing			
Controlling Body Temperature			
Communication			
Cognition			
Eating and Drinking			
Cooking/Meal Preparation			
Housekeeping			
Managing Medications			
Managing Finances			
Eliminating (Toileting & Continence)			
Personal Hygiene			
Dressing			
Controlling Body Temperature			
Mobilising (Indoors)			
Mobilising (Outdoors)			
Working and Playing			
Expressing Sexuality			
Sleeping			
Dying (where applicable)			

- Hand Dominance:
  (Right □ Left □ Ambidextrous □)

- Exercise Tolerance:
  - Prior to Injury:
  - Post-Injury:
    Biomechanics - eg gait, mobility

11. Goals and Outcomes:

- **Short-Term Goals:** (0-3 months, 3-6 months)
- *(e.g., improve mobility with aids, regain independence in dressing)*
- **Medium-Term Goals:** (3-12 months)
  (e.g., resume community activities, reduce support needs for meal prep)
- **Long-Term Goals:** (12+ months)
  (e.g., return to work, maintain independent living)
- Detail specific interventions and supports needed to achieve these goals.

For each goal:

Goal	Target Date	Current Barriers	Required Interventions
Example: Walk unaided	DD/MM/ YYYY	Decreased balance/ Decreased proprioception	Physiotherapy, balance exercises

12. Environmental and Social Assessment:

- **Living Situation:** House, apartment, care home/warden controlled living.

- **Home Environment Assessment:** Accessibility, safety, equipment needs.
  - Are there areas of the home that are difficult to navigate? [ ] Yes [ ] No
    - If yes, specify:

      _____
  - Are assistive devices or modifications needed (e.g., grab bars, ramps)? [ ] Yes [ ] No

Transportation:

- Does the client have reliable access to transportation? [ ] Yes [ ] No
  - Barriers:

    _____

Social Support

Support Network:

- Who provides emotional/physical support? _____
- Does the client engage with friends, clubs, or other social activities? [ ] Yes [ ] & NNo
  - If yes, specify:

    _____
- Who is their best/closest friend or confidant? _____

Hobbies:

Were you active in sports or physical activities before the injury?
What were your typical daily routines before the injury?

Community Engagement:

- Is the client able to participate in community or leisure activities? [ ] Yes [ ] No
  - Barriers:

    _____

Support System: Who provides you with emotional or physical support at home?
Isolation Risks: Do you feel isolated or disconnected from your community or loved ones?

Financial Situation

Income/Benefits:

- Does the client require financial assistance to manage their care or living expenses? [ ] Yes [ ] No
- Are they aware of financial education or budgeting resources? [ ] Yes [ ] No
  - Notes:
    _____

13. Client Values and Priorities Section

1. What brings you joy or fulfilment in life?
2. What are the most important goals for you right now? (Think in terms of hours, days, weeks):
   - In the next 1–4 hours: _____
   - Over the next 1–6 days: _____
   - In the next 1–6 weeks: _____
3. What would you like to achieve in the next 1–3 months?
4. hobbies or activities do you enjoy and how can we help you reconnect with them?
5. Are there cultural, spiritual, or personal values you'd like us to consider in your care plan?

14. **Emotional & Psychological Wellbeing:**

Current Emotional State

A. How have you been feeling emotionally in the past week?
   - Nervous or anxious
   - Down, depressed, or hopeless
   - Angry or irritable, bitter
   - Other: _____
B. What has been the most difficult part of your recovery journey so far?
C. Are there specific events or triggers that cause emotional distress?

Coping Strategies and Support

A. What helps you feel calm or supported during stressful times?
B. Do you have someone you can talk to about your feelings or concerns?
   Yes
   No (Would you like help finding support resources? [ ] Yes [ ] No)
C. Are there any professional support systems in place (e.g., therapy, counselling)?
   Yes (Specify): _____
   No

Psychological Impact on Daily Life

A. Do your emotions affect your ability to perform daily activities (e.g., ADLs, work, social interactions)?

   Yes
   No
   If yes, describe: _____
B. Do you find it difficult to focus or concentrate on tasks?
   Yes
   No
C. Have you experienced changes in your sleep patterns or appetite?
   Yes
   No

Future Emotional Well-Being

A. What are your top priorities for improving your emotional health?
B. What goals would you like to set for your emotional well-being in the short term (1–6 weeks)?

Reflecting Back on Dreams and Values

- What dreams or values inspire you as you move forward in your recovery?

15. Sign-Off and Acknowledgment

1. Client Acknowledgment

- I confirm that the information I have given to the assessor in the Initial/Immediate Needs Assessment is an accurate and truthful representation of my situation. I give my full consent to this being used as a basis for a comprehensive report, to represent the details of my injury/injuries and current situation and given to my legal team and potentially to a court of law.

    - **Client/Guardian Name**: _____
    - **Signature**: _____
    - **Date**: _____

2. Assessor's Confirmation

- I confirm that this INA has been conducted in accordance with professional standards and that the client's values and preferences have been respected and consent has been obtained and agreed.

- **Assessor Name**: _____
- **Signature**: _____
- **Date**: _____

Optional Add-On: Witness (If Required)

- I, the witness, confirm that I was present during this INA and that the client/ guardian's acknowledgment was provided freely and without coercion.
  - **Witness Name**: _____
  - **Signature**: _____
  - **Date**: _____