CLIENT SUPPORT PLAN

REFERRAL DETAILS

Referring Agency: (Name & Address)	Auckland	**Referral Date**	2025-05-01 00:00:32
Case Manager / Contact Name		**Phone/Email**	
ACC Claim Number	ACC0105202502	**NHI Number**	
ACC Date of Injury		**Purchase Order**	PO0105202502
Service Type	ACC0105202502	**Minimum Support Worker Skill Level Required**	Level 2
Review Date	2025-05-31	**Acuity Level**	

CLIENT PERSONAL INFORMATION

Full Name	Auckland	**Date of Birth**	01/05/1989 12:00:00 AM
Address	415, Ilam Road, 8053, Bryndwr, Christchurch, Auckland	**Gender**	Female
Phone	64-2232-02222222222	**Smoker/Vape**	No
Email	mark@yahoo.com	**Enduring Power of Attorney / Advocate**	Enacted test
Ethnicity Which ethnic group (s) do you belong to?		**Spiritual / Cultural Taha wairua**	Religion Spiritual /Cultural Needs Cultural Support Offered Decline
Next of Kin / Emergency Contact (relationship)	Emeregncy 1	**Contact Details (address/phone)**	1, Aberdeen Avenue, 4412, Takaro, Palmerston North /M: 64-4455-02222222222
GP Name / Practice		**Contact Details (address/phone)**	
Pharmacy		**Contact Details (address/phone)**	
GP Consent (to contact GP)		**Health One/ Health Connect South Access**	
Consent to upload Care Plan to Health One			
Do Not Resuscitate (DNR)	Discussed with client ☐ Yes ☐ No		
	DNR documentation identified ☐ Yes ☐ No		
	Where is DNR documentation stored		
	DNR on Health One/ Health Connect South ☐ Yes ☐ No		
	Special requests or cultural preferences:		
	DNR discussed with family/ whanau as to client wishes?		
	Family/ whanau acknowledge client not for CPR?		

CLINICAL DETAILS

Date of initial contact	
Date of initial assessment / first episode of care	2025-04-28

Support person offered during initial assessment / ISP development			
If timeframes for initial contact not met, state reason		Other	
Presenting Situation			
Living Situation			
Family / Whanau Wellbeing Taha whanau			
Links with other services (formal supports)	N/A – Not Applicable,Physiotherapist,Occupational Therapist,Nursing,Podiatrist,Spinal,Social Worker,Psychologist,Other		
Mobility			
Medications			
Alerts / Warnings / Cautions / Values (eg. values / medical alarm / hazards)			
Allergies			

TE AO MĀORI/TIKINGA/CULTURAL SUPPORT QUESTIONS

Phoenix Healthcare would like to support our kiritaki to engage in Te Ao Māori/their culture and have options to support you to do so. Answering all or some of the following questions will allow us to explore these support options for you via our cultural advisor, with your consent to reach out to discuss these.

If cultural support or tikinga is not required or declined, please note this in the corresponding box.

Do you identify with an: iwi Hapu	
Marae	
What is your support base in the community?	
Do you have any issues accessing those community supports, if so what?	
How would you like our staff to greet you when they arrive e.g. in Te Reo Māori?	
Are there any practices relating to your bathing or the washing of your clothes that you would like us to know about?	

To support kiritaki to engage Te Ao Māori further if desired, suggest registration with Tāngara Waikaha Whānau National Peer group online and with iwi rūnanga if not already done so.

What brings you joy?	
Interests & hobbies Community & social involvement Work & voluntary activities	

HUA ORANGA (Pathways to Wellbeing)

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Have a few more questions so we can understand a bit more about what helps you feel joy.
These are questions ask about different areas of your life that are important to wellbeing. For each question you are asked to rate your response from 1 (strongly disagree) to 5 (strongly agree). There are no right or wrong answers. Completing this will highlight your strengths and challenges, and we can discuss these when setting some goals for our work together.

These questions are about taha tiana or your physical health	**1**	**2**	**3**	**4**	**5**
At this point in time do you feel:	Strongly disagree				Strongly agree
Able to move without pain or distress					
I have goals to maintain or improve my physical wellbeing					
I believe physical health improves my general wellbeing, including mental wellbeing					

These questions are about taha wairua or your spiritual health	**1**	**2**	**3**	**4**	**5**
At this point in time do you feel:	Strongly disagree				Strongly agree
My mana is intact and acknowledged/respected					
Strong in my cultural identity					
Content within yourself					
Connected and healthy from a spiritual (Wairua and Mauri) perspective					

These questions are about taha whānau or your family health	**1**	**2**	**3**	**4**	**5**
At this point in time do you feel:	Strongly disagree				Strongly agree
Able to talk with my whānau and others					
My relationships with whānau and others are healthy					
Clear about my roles within my whānau/family and how to fulfil them.					
Able to participate in community, or hapū and iwi activities.					

These questions are about taha hinengaro or your mental health	**1**	**2**	**3**	**4**	**5**
At this point in time do you feel:	Strongly disagree				Strongly agree
I want to make changes in my life that contribute to my wellbeing					
Able to think, feel and act in a positive manner					
Able to manage unwelcome thoughts and feelings					
I understand what contributes to my concerns and how to address these.					

Scoring: Sum each individual taha to identify any areas of challenge (see scoring guide below)
Sum all 4 taha scores to produce an overall score.

Taha/Dimension	**Score**
Taha tiana / physical health	0
Taha wairua / spiritual health	0
Taha whānau / family health	0
Taha hinengaro / mental health	0

Overall Score
0

SCORING GUIDE				
	Very Low	Low	Hight	Very High
Taha scale	4-8	9-12	13-16	17-20

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Overall scale	16-32	33-48	49-64	65-80
	Areas of challenge		Areas of strength	

GOAL PLANNING
If you could make improvements (a step at a time) in any for the four areas (taha) what would it/they be?.
What would be different if you could make these changes to strengthen or balance the areas (taha) of your wellbeing? How would life change for you?
What first step (change) could you attempt to move in this direction? What would it take for you to live this way for two weeks?
Are there other areas of life important for you currently? Such as work, recreation/hobbies, education. Write any other areas that you would like to focus on:

My short-term goal(s):
My long-term goal(s):

Goal Ladder Weeks (i.e. Week 1,2,3,4 OR Weeks 1-2, 2-4)	**Incremental steps to achieve** (Agreed with client)

Essential Public Holiday Arrangements Required	
Service Type:	Complex Support,District Nursing

Payer	Service Name	Service hours per week	Total number of hour	Starts Date	End Date
ACC Access-HCSMI	HCS30 - Home & Comm Support Max Indep-Support Hrs Standard	10.00	60.00	2025-02-01 00:00:00	
ACC Access-HCSMI	HCS31- Home & Comm Support Max Indep-Complex Hours	10.00	60.00	2025-02-01 00:00:00	

WEEKLY OVERVIEW			
Day	Times	Tasks/Duties	Length
MON			
TUE			
WED			
THU			
FRI			
SAT			

SUN			

SHOPPING			
	Yes	**No**	**Comments, Supports and Interventions required**
Shopping Assistance Required	☐	☐	Our policy is that we do not access bank accounts or handle cash. Clients must not give out bank cards or PIN numbers to Support Workers.
Online/Phone Order	☐	☐	
SW to do shopping from list	☐	☐	
SW to assist client	☐	☐	
Use client's car	☐	☐	
Use SW car	☐	☐	

POTENTIAL HAZARD IDENTIFICATION FORM

L = Likelihood	1 very rare	2 unlikely	3 moderate	4 likely	5 almost certain
C = Consequence	1 Minor first aid	2 medical treatments	3 lost time injury	4 serious harm	5 fatality
RR = Risk Rating (L + C):	Low Risk: 2,3,4	Medium Risk: 5,6,7	High/Extreme Risk: 8,9,10		

Identified or Potential Hazard	**Y**	**N**	**L**	**c**	**RR**	**Action Eliminate Isolate Minimise**	**Process**
Physical Hazards							
Loose mats	☐	☐					
Slippery Surfaces (in & out)	☐	☐					
Obstacles on floor	☐	☐					
Steps/ladders	☐	☐					
Uncontrolled movements/spasm	☐	☐					
Electrical Hazards							
Overloaded power sockets	☐	☐					
Faulty Appliances	☐	☐					
Loose wires / frayed cords	☐	☐					
Biological Hazards							
Infectious disease	☐	☐					
Sharps / Needles	☐	☐					
Antibiotic resistance	☐	☐					
Unused Food / use by dates	☐	☐					
Animal Hazards							
Unrestrained/aggressive animals	☐	☐					
Rodent/Fleas/Insect infestation/excreta/urine	☐	☐					
Chemical Hazards							
Strong Chemicals	☐	☐					
Storage / Labelling	☐	☐					
Ventilation	☐	☐					
Gas Heater	☐	☐					

Ergonomic Hazards							
Low work surfaces e.g. bed	☐	☐					
Heavy / Awkward loads and postures	☐	☐					
Repetitive movements	☐	☐					
Psychological Hazards							
Challenging Behavior	☐	☐					
Emotional work environment	☐	☐					
Client Safety							
Employee awareness of clients' needs	☐	☐					
Any barriers identified around accessibility of healthcare services	☐	☐					
Enablers and Equipment							
Equipment service UTD i.e.: wheelchair/hoist49	☐	☐					
Transportation							
WOF and REGO of vehicle to be used UTD, checked via Waka Kotahi website	☐	☐					
Licence Plate Details	☐	☐					
Insurance details	☐	☐					
Other							
Other	☐	☐					

SERVICE PLAN – COMPLEX SUPPORT

HOME AND COMMUNITY INFORMATION	

COMMUNICATION	Yes	No	Comments, Supports and Interventions required
Verbal	☐	☐	
Non-Verbal	☐	☐	
Hearing Impaired	☐	☐	
Aids / Technology Required	☐	☐	
SW language requirements	☐	☐	
Interpreter Required	☐	☐	
Other	☐	☐	

PHYSICAL HEALTH	Yes	No	Comments, Supports and Interventions required
Diabetic IDDM / NIDDM	☐	☐	
Memory Loss	☐	☐	
Sight Impaired	☐	☐	
Comprehension Impaired	☐	☐	
Cognition Impaired	☐	☐	
Asthma	☐	☐	
Epilepsy	☐	☐	
MRSA / ESBL	☐	☐	

Infectious / notifiable diseases & description of protocols to be used (E.g.: Hepatitis B)	☐	☐	
Heart Disease	☐	☐	
Autonomic Dysreflexia	☐	☐	
Other	☐	☐	

MENTAL WELLBEING Taha hinengaro	**Yes**	**No**	**Comments, Supports and Interventions required**
Sleep Hygiene	☐	☐	
Depression	☐	☐	
Anxiety	☐	☐	
Other	☐	☐	

MEDICATION	**Yes**	**No**	**Comments, Supports and Interventions required**
Medications Required	☐	☐	
Fully independent	☐	☐	
Client directed assistance	☐	☐	
SW responsible	☐	☐	
Blister Packed	☐	☐	
Controlled Drugs	☐	☐	
Medication signing	☐	☐	
Allergies	☐	☐	
Other	☐	☐	

MOBILITY	**Yes**	**No**	**Comments, Supports and Interventions required**
Independent	☐	☐	
Limb weakness - R / L	☐	☐	
Able to weight bear	☐	☐	
Mobility aids	☐	☐	
Transfers ☐ Standing ☐ Full hoist ☐ Sliding board ☐ Other	☐	☐	
Falls risk assessment Appendix A	☐	☐	
Falls prevention plan	☐	☐	
Wheelchair - power/manual	☐	☐	
Transfer equipment	☐	☐	
Carer assistance	☐	☐	
Aids, enablers, restraints	☐	☐	
Passive exercises / exercise routine	☐	☐	
Safety risk	☐	☐	
Transport assistance	☐	☐	

Equipment maintenance	☐	☐	
Other	☐	☐	

PERSONAL SUPPORT	Yes	No	Comments, Supports and Interventions required
Independent	☐	☐	
Shower / Bath	☐	☐	
Equipment (eg. commode)	☐	☐	
Transfers required	☐	☐	
Wet area shower	☐	☐	
Shower over bath	☐	☐	
Clean shower area after use	☐	☐	
Dressing assistance	☐	☐	
Hair care	☐	☐	
Dental / oral care	☐	☐	
Shaving/cosmetic assistance	☐	☐	
Nail care assistance	☐	☐	
Make bed / change linen	☐	☐	
Other	☐	☐	

URINARY MANAGEMENT	Yes	No	Comments, Supports and Interventions required
Continent	☐	☐	
Independent	☐	☐	
Catheter Continence products ☐ IDC ☐ SPC ☐ Uridome	☐	☐	
Fluid intake assistance / encouragement	☐	☐	
Catheter irrigation	☐	☐	
Catheter nursing care	☐	☐	
Input / output record	☐	☐	
Other	☐	☐	

BOWEL MANAGEMENT	Yes	No	Comments, Supports and Interventions required
Continent	☐	☐	
Independent	☐	☐	
Suppositories / Enema	☐	☐	
Digital stimulation	☐	☐	
Manual evacuation	☐	☐	
Colostomy / Ileostomy care	☐	☐	
Haemorrhoids	☐	☐	
Haemorrhoids	☐	☐	

NUTRITION / HYDRATION	Yes	No	Comments, Supports and Interventions required
Normal diet	☐	☐	
Diabetic / Special diet	☐	☐	
Meal preparation	☐	☐	
Supervision	☐	☐	
Eating / drinking assistance	☐	☐	
Aids / enablers / equipment	☐	☐	
Food allergies	☐	☐	
Food and fluid chart	☐	☐	
PEG/NGT feeding	☐	☐	
Malnutrition Screening tool Appendix B	☐	☐	
Other	☐	☐	

SKIN CARE	Yes	No	Comments, Supports and Interventions required
Intact	☐	☐	Braden assessment completed (see below). Score: ___ Pressure injury prevention plan • Transfer and lifts – reduction of friction and shear forces using hoist • Incontinence management plan (regular checks and changes, correct products in use, barrier cream use, bowel incontinence management plan i.e. retraining) • Skin checks and reporting on findings in notes • Regular change of position (at least 2 hourly during the day) • Pressure relief devices e.g. air mattress • Stretches and exercise plan • Prevention of contractures and pressure points • Fingernails kept short • good nutrition • non-restrictive clothing
Sensation impairment	☐	☐	
Pressure area risk	☐	☐	
Daily checks	☐	☐	
Moisturiser / creams	☐	☐	
Temperature regulation	☐	☐	
Current skin damage / wounds	☐	☐	
Wound nursing care Who is providing this and when	☐	☐	
Scale completed Appendix C	☐	☐	
Other	☐	☐	

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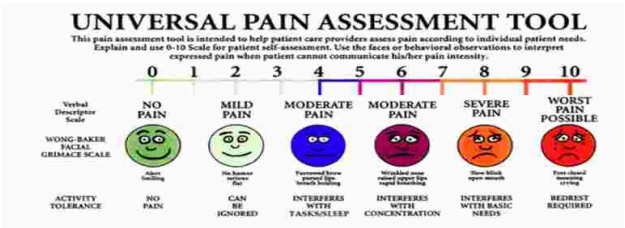
RESPIRATORY	Yes	No	Comments, Supports and Interventions required
Independent	☐	☐	
Assisted cough / Deep breathing exercises required	☐	☐	
Aspiration risk	☐	☐	
Chest infection risk	☐	☐	
CPAP	☐	☐	
CPAP management plan	☐	☐	

OVERNIGHT SUPPORT	Yes	No	Comments, Supports and Interventions required
Independent	☐	☐	
Awake / Sleepover care	☐	☐	
Repositioning	☐	☐	
Toileting assistance	☐	☐	
Equipment	☐	☐	
Other	☐	☐	

PAIN	Yes	No	Comments, Supports and Interventions required
Pain concerns	☐	☐	
Spasm / Cramp concerns	☐	☐	
Analgesia required	☐	☐	
Pain management plan	☐	☐	
Other	☐	☐	



PSYCHOLOGICAL SUPPORT	Yes	No	Comments, Supports and Interventions required
Required support with:			
Orientation	☐	☐	

			Behaviour management plan Developed collaboratively with the client to reduce the impact and frequency of behaviours of concern. It provides practical ideas to improve safety if these behaviours occur. Behaviour/s of most safety concern that this plan will address verbal aggression, physical aggression, self-harm, inappropriate social behaviour, other (cross out behaviours not applicable) Triggers to be aware of pain, fatigue, client has been waiting, client has been asked to stop something, client has perception of being let down, client has partaken in drugs / alcohol, there have been conversations about the client in front of them, client being told no, post seizure (cross out triggers not applicable). Other: How to minimise triggers: positivity, explanation, ask for the behaviour to stop in a calm voice, redirect, other: Staff safety includes withdrawal if perception indicative of potential harm and • Record and report on any physical or verbal aggression and possible cause • Complete an incident form • Complete behaviours that challenge forms • Remedy cause if possible • Reassure client • Avoid unnecessary interventions that upset client • Remove self from within reach • Contact office • Respond in a calm voice and acting calmly towards client • Ignore bad language • Offer analgesia prior to management of personal cares • Proactive management of risk e.g. warning people to stay at arm's length to avoid being struck if client is angry and frustrated, pre planning the day, sticking to regular routines • Limiting social or community visits to times when client is rested/has had analgesia and is more likely to cope-effectively • Specifics for client:
Insight	☐	☐	
Motivation	☐	☐	
Mood / anxiety	☐	☐	
Fatigue	☐	☐	
Organisation / planning	☐	☐	
Concentration	☐	☐	
xrTableCell1344	☐	☐	
Support with home administration & finances	☐	☐	
Safety judgement risk	☐	☐	
Substance use	☐	☐	
Behaviours that challenge	☐	☐	
Behavioural support plan	☐	☐	

Summary of Terms and Conditions

This document forms part of the terms and conditions together with your care plan and are binding by signing.
I understand that I (as the client) have the right to:

- Be fully informed of Phoenix Healthcare Group's services.
- Be treated with dignity and respect.
- Have my cultural and personal background, age, beliefs, and values respected.
- Be consulted about decisions that affect me.
- Receive information in a form that I can understand.
- Have my privacy and confidentiality respected.
- Have access to see and correct all the information about me kept by Phoenix Healthcare Group Ltd and to know how that information will be used.
- Have the right to refuse service or withdraw from the service. The withdrawal from services may be made by either party after consideration of the specific circumstances involved.
- Choose or change my Support Worker(s).
- Raise any concerns I have about the service and have them dealt with promptly.
- Nominate someone else to be my agent/advocate in dealing with service providers.

I understand that I am responsible for:

- Providing all cleaning supplies and equipment, toilet and drinking water facilities (and maintaining equipment to a safe standard) as detailed above.
- Providing a safe working environment for Support Workers as per the list in the above section.
- Treating Support Workers with dignity, respect, and in a non-discriminatory manner.
- Informing the Phoenix Healthcare office if I will not be home when a care visit is due to take place.
- Informing the Phoenix Healthcare office as soon as possible if I contract an infectious or contagious illness.
- Any repair/replacement costs involved around chattels and equipment.

I agree that:

- I have been involved in the development of my Goals and Care Plan
- I will work with my Support Worker(s) to achieve my goals.
- I will make my Care Plan available to Support Workers at my home.
- I will not make my financial, bank account or PIN details available to Support Workers.
- I will not privately contract or employ Phoenix Healthcare Group's Support Workers to provide services available through Phoenix Healthcare or I may be liable to pay a penalty (up to $3000).
- I will not contact Phoenix Healthcare support workers directly under any circumstances.
- My personal information has been collected for statistical reporting and to assist in the provision of care outlined in my Care Plan.
- My personal information may be shared with Phoenix Healthcare relevant office staff, Coordinators, Case Managers, and external agencies and service providers such as general practitioners, specialists, therapists, and auditors with whom Phoenix Healthcare may be required to liaise from time to time, only as necessary for the provision of my care.
- This consent applies for the whole period during which Phoenix Healthcare Group provides my care, unless I negotiate a different arrangement with Phoenix Healthcare.
- Phoenix Healthcare Group will keep my personal information stored securely for a minimum of 10 years as per legal obligation and access will only be available to authorized office personnel.
- Phoenix Healthcare Group reserves the right to withdraw services if I do not give my consent for the Support Workers to enter my home and provide care as specified by the Care Plan.
- Phoenix Healthcare Group will supply me with a signed copy of my Care Plan.

If a Support Worker is at your home when an emergency occurs, they will take all steps practicable to keep you and themselves safe. Please advise the following:

Smoke alarms?	☐	No	☐	Yes	
Emergency plan? Where is it located?	☐	No	☐	Yes	
Emergency Survival / Getaway kit? Where is it located?	☐	No	☐	Yes	
Fire Extinguisher / Fire blanket? Where is it located?	☐	No	☐	Yes	
Where is your Water Connection (Toby)?	☐	No	☐	Yes	
Where is your Electricity switchboard?	☐	No	☐	Yes	
Evacuation Plan (for Immobile / High Needs)	☐	No	☐	Yes	

☐ **I have participated in the development of my Individual Service Plan and agree with the terms and conditions**

I have received and/or discussed the following

☐ Client Service Information

☐ Code of Health and Disability Services Consumer Rights

☐ Communication Book

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- [ ] Household Emergency Plan and Checklist

Additional Documentation (tick as required)

- [ ] Consent to transport children
- [ ] Consent to drive client's vehicle
- [ ] Key holder agreement
- [ ] Policy on Smoking / Smokefree workplace

APPENDIX A – Falls Risk Assessment

Part 1 – Falls Risk Status

Risk Factor	Level	Risk Score
RECENT FALLS	None in the last 12 months One or more between 3 and 12 months One or more in the last 3 months One or more in the last 3 months whilst inpatient	
MEDICATIONS (sedatives, anti-depressants, anti-parkinsons, diuretics, anti-hypertensives, hypnotics)	Not taking any of these Taking one Taking two Taking more than two	
PSYCHOLOGICAL (anxiety, depression, reduced cooperation, reduced insight, or reduced judgement)	Does not appear to have any of these. Appears mildly affected by one or more. Appears moderately affected by one or more. Appears severely affected by one or more	
COGNITIVE STATUS	Intact Mildly impaired Moderately impaired Severely impaired	
Low risk = 5-11 (Provide standard care and follow general patient safety principles) **Medium risk** = 12-15 (risk factors have been identified and interventions listed in Action Plan) **High risk** = 16-20 (high likelihood of falls, interventions listed in Action Plan. Liaise with OT/PT/CM)		
Notes		

Part 2 – Risk Factor Checklist

Vision	None in the last 12 months One or more between 3 and 12 months One or more in the last 3 months One or more in the last 3 months whilst inpatient	☐
Mobility	Mobility status unknown or appears unsafe/impulsive/forgets gait aid	☐
Transfers	Transfer status unknown or appears unsafe	☐
Behaviours	Observed or reported agitation, confusion, disorientation, non-compliant	☐
ADL's	Unsafe use of equipment Unsafe footwear	☐
Environment	Difficulties with orientation to environment	☐
Nutrition	Underweight/low appetite	☐
Continence	Reported or known urgency/nocturia/accidents	☐
Other	Osteoporosis, history of fractures	☐

Part 3 – Action Plan

For risk factors identified in Parts 1 & 2, list strategies below to manage falls risk.

Problem List	Intervention strategies/referrals

	1)	Wear enclosed firm soled shoes
	2)	Remove home hazards such as clutter
	3)	Immediately clean up spills/water
	4)	Use nonslip mats in bathroom/shower and on any slippery surface
	5)	Secure loose rugs
	6)	Ensure adequate lighting
	7)	Use assistive devices such as handrails/ raised toilet seat/ grab bars.
	8)	Ensure support workers are training in manual handling.

APPENDIX B – Malnutrition Screening Tool

Malnutration Screening Tool (MST)

STEP 1: Screen with the MST	
Have you recently lost weight without trying?	
No	0
Unsure	2
If yes, how much weight have you lost?	
2-13 lb	1
14-23 lb	2
24-33 lb	3
34 lb or more	4
Unsure	2
Weight loss score:	**0**
Have you been eating poorly because of a decreased appetite?	
No?	0
Yes?	1
Appetite score:	0
Add weight loss and appetiate score	
MST SCORE:	**0**

STEP 2: Score to determine risk
MST = 0 OR 1
NOT AT RISK
Eating well with little or no weight loss.
If length of stay exceeds 7 days, then rescreen, repeating weekly as needed.
MST = 2 OR MORE AT RISK
Eating poorly and/or recent weight loss
Rapidly implement nutrition interventions. Perform nutrition consult within 24-72 hrs, depending on risk.
STEP 3: Intervene with nutritional support for your patients at risk of malnutrition.

APPENDIX C – Braden Scale

RISK FACTOR	SCORE/DESCRIPTION				1	2	3	4
SENSORY PERCEPTION Ability to respond to pressure-related discomfort.	**1 Completely limited –** Unresponsive (does not moan, flinch, or gasp) to painful stimuli, due to diminished level of consciousness or sedation, OR limited ability to feel pain over most of body surface.	**2 Very limited** Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness. OR has a sensory impairment which limits the ability to feel pain or discomfort over ½ of body.	**3 Slightly limited** -Responds to verbal commands but cannot always communicate discomfort or need to be turned, OR has some sensory impairment which limits ability to feel pain or discomfort in 1 or 2 extremities.	**4 No Impairment** -Responds to verbal commands. Has no sensory deficit which would limit ability to feel or voice pain or discomfort.				
MOISTURE	**1 Constantly Moist**	**2 Often Moist**	**3 Occasionally Moist**	**4 Rarely Moist**				

Degree to which skin is exposed to moisture.	kept moist almost constantly by perspiration, urine, etc. Dampness is detected every time client (kiritaki) is moved or turned.	-Skin is often but not always moist. Linen must be changed at least once a shift.	-Skin is occasionally moist, requiring an extra linen change approximately once a day.	-Skin is usually dry; linen only requires changing at routine intervals.				
ACTIVITY Degree of physical activity.	**1 Bed fast.** -Confined to bed.	**2 Chairfast** -Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair.	**3 Walk Occasionally** -Walks occasionally during day but for very short distances with or without assistance. Spends majority of each shift in bed or chair	**4 Walks frequently** -Walks outside the room at least twice a day and inside room at least once every 2 hours during waking hours.				
MOBILITY Ability to change and control body positions.	**1 Completely Immobile** -Does not make even slight changes in body or extremity position without assistance.	**2 Very Limited-** Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently	**3 Slightly Limited** -Makes frequent though slight changes in body or extremity position independently.	**4 No Limitations** -Makes major and frequent changes in position without assistance.				
NUTRITION Usual food intake pattern. NPO=Nil by mouth IV=Intravenously TPN=Total parenteral nutrition	**1 Very Poor** -Never eats a complete meal. Rarely eats more than 1/3 of any food offered. Eat x2 servings or less of protein (meat or dairy products) per day. Takes fluids poorly. Does not take liquid dietary supplement, OR is NPO and/or maintained on clear liquids or IV for more than 5 days	**2 Probably Inadequate** -Rarely eats a complete meal and generally eats only about ½ of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take dietary supplement, OR receives less than optimum amount of liquid diet or tube feeding.	**3 ADEQUATE** -Eats over half of most meals. Eat a total of 4 servings of protein products each day. Occasionally refuses a meal, but will usually take a supplement if offered, OR is on tube feeding or TPN regimen, which probably meets most nutritional needs.	**4 EXCELLENT** -Eats most of every meal. Never refuse a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.				
FRICTION AND SHEARING	**1 Problem** Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in the bed or chair, requiring repositioning often with maximum assistance. Spasticity, contractures or agitation leads to constant friction.	**2 Potential Problem** -Moves feebly or requires assistance. During move, skin probably slides against the sheets, chair, restraints, or other devices. Maintains relatively good position in chair or bed most of the time but occasionally slides down.	**3 No Apparent Problem** -Moves in bed and chair independently and has sufficient muscle strength to lift up completely during move. Maintains good position in bed or chair at all times.	**NB/ Total Score of 12 or less represents** **HIGH RISK** **TOTAL SCORE:** 0				

ACCEPTANCE AND ACKNOWLEDGEMENT

Client Name		**Signature**		**Date**	

Phoenix Representative		**Signature / Designation**		**Date**	
Authority Details An authority has the legal right to sign for another person if for some reason they are unable to consent on their own behalf		**Signature / Relationship to client**		**Date**	

CONTACT INFORMATION

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