

ASSESSMENT FOR ADMISSION TO HOMES FOR FRAIL PERSONS / SUPPORT NEEDS FOR OLDER PERSONS

DQ98

[Do not write in the shaded areas. Tick where appropriate.]

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SECTION 1: REGISTRATION DETAILS										
A. ORGANISATION:				Registration No:		Date of registration:				
Date of notification:				Assessment completed on:		Date of admission:				
Type of Assessment:			Urgency:		Place of Assessment:					
<input type="checkbox"/>	New notification		<input type="checkbox"/>	Within 24 hours		<input type="checkbox"/>	Own dwelling		<input type="checkbox"/>	Hospital
<input type="checkbox"/>	Revision		<input type="checkbox"/>	Within 1 week		<input type="checkbox"/>	Home for Aged		<input type="checkbox"/>	Clinic
<input type="checkbox"/>	Re-assessment		<input type="checkbox"/>	Within 1-3 weeks		<input type="checkbox"/>	Sheltered accommodation		<input type="checkbox"/>	Other
<input type="checkbox"/>	Appeal		<input type="checkbox"/>	Other		<input type="checkbox"/>	Community Centre			
Reason for referral:				Assessor's name		Occupation				Reference source:
B. CLIENT'S PERSONAL DETAILS:										
Surname:					Marital Status:		<input type="checkbox"/> Centre member			
Full name:							<input type="checkbox"/> Nursing services			
First name and initials:							<input type="checkbox"/> Group (Club)			
Address:							<input type="checkbox"/> Social worker			
							<input type="checkbox"/> Church			
							<input type="checkbox"/> Hospital			
Tel No:							<input type="checkbox"/> Family member			
Date of birth/Age: (ID Number)					Gender:		<input type="checkbox"/> M	<input type="checkbox"/> F	<input type="checkbox"/> Other	
Race: (for statistical purposes)					ACCOMMODATION:		FAMILY COMPOSITION:			
					<input type="checkbox"/> Owner		<input type="checkbox"/> Lives in old age home			
					<input type="checkbox"/> Tenant		<input type="checkbox"/> Lives alone			
					<input type="checkbox"/> House		<input type="checkbox"/> With spouse			
					<input type="checkbox"/> Flat		<input type="checkbox"/> With children/child			
					<input type="checkbox"/> Retirement complex		<input type="checkbox"/> With other family			
					<input type="checkbox"/> Private home/guest house/ hotel		<input type="checkbox"/> With other elderly			
					<input type="checkbox"/> Informal /Squatter settlement		<input type="checkbox"/> With non-family (friends)			
					<input type="checkbox"/> Housing scheme		<input type="checkbox"/> Extended family			
					<input type="checkbox"/> Tribal (rural)		<input type="checkbox"/> Rural extended family			
					<input type="checkbox"/> Farm labourer		<input type="checkbox"/> With parents			
					<input type="checkbox"/> Old age home		<input type="checkbox"/> Please state number of persons in the household			
					<input type="checkbox"/> Other					
SOURCE OF INCOME:					GROSS INCOME PER MONTH:					
<input type="checkbox"/>	Disability Grant		<input type="checkbox"/>	Individual		<input type="checkbox"/>	Couple			
<input type="checkbox"/>	Old Age Pension		Total Monthly Income per household: R							
<input type="checkbox"/>	War Veterans									
<input type="checkbox"/>	Other (private)									
Specify details of financial dependants:					<input type="checkbox"/> Informal /Squatter settlement		<input type="checkbox"/> With non-family (friends)			
					<input type="checkbox"/> Housing scheme		<input type="checkbox"/> Extended family			
					<input type="checkbox"/> Tribal (rural)		<input type="checkbox"/> Rural extended family			
					<input type="checkbox"/> Farm labourer		<input type="checkbox"/> With parents			
					<input type="checkbox"/> Old age home		<input type="checkbox"/> Please state number of persons in the household			
					<input type="checkbox"/> Other					

2. ACTIVITIES OF DAILY LIVING (ADLs)										
Eating	Dressing upper	Dressing lower	Personal hygiene	Bathing	Toileting	Medications	Mobility	Communication	Transfers	
0	0	0	0	0	0	0	0	0	0	Fully independent
3	1	2	2	1	3	3	2	2	0	Independent with aid-devices
3	1	2	2	1	3	5	4	N/A	2	Needs supervision, but can manage on own
3	2	3	2	2	5	8	6	6	2	Needs regular supervision and help with certain tasks
10	3	4	6	4	8	10	6	6	9	Needs help of one person
N/A	6	8	N/A	6	10	N/A	8	N/A	11	Needs help of two persons
13	N/A	N/A	10	N/A	13	13	10	10	N/A	Needs continuous care
3	6	8	6	6	10	8	10	2	11	SCORE FOR EACH ITEM
									70	TOTAL SCORE FOR "ADLs"
REMARKS:										

3. MENTAL FUNCTIONING		
0	No support required	
3	Observes accepted social standards with support	
3	Behaviour is unusual but does not offend others or endanger self	
13	Behaviour disturbing to others at times but not a danger to self or others	
23	Continuous, uncontrollable, demanding behaviour	
25	Behaviour dangerous / risk to him/herself / other people	
	REMARKS; eg Markedly unmotivated / lonely / depressed / aggressive	
Yes	No	Would the client benefit from a Psychiatric assessment?
TOTAL SCORE for "Mental functioning"		23

4. PRIMARY NEEDS		<input type="checkbox"/> Not applicable (institutionalised)		
Water	Food	Toilet	Safety	Key
0	0	0	0	Available
11	11	8	10	Limited
22	22	16	20	Inaccessible / dangerous
28	28	20	24	Not available
TOTAL SCORE FOR "PRIMARY NEEDS" :			<input type="text"/>	<input type="text"/>
5. COMMUNITY INFRASTRUCTURE		<input type="checkbox"/> Not applicable (institutionalised)		
Transport	Telephone	Post Office		
			Available	
			Limited	
			Inaccessible	
			Not available	
6. SUPPORT SYSTEMS AVAILABLE TO CLIENT		<input type="checkbox"/> Not applicable (institutionalised)		
0	Support system (spouse, family, friends) functioning well			
20	Support system available, but not functioning well			
3	Living alone with access to other support systems			
13	Only formal support systems			
33	Support system available, but exploitation / abuse / neglect suspected			
26	No support system available			
<input type="text"/>	Section 6 score			
7. GENERAL FUNCTIONING OF CARE-GIVER:		<input type="checkbox"/> Not applicable (institutionalised)		
0	Care-giver fully in control of the situation			
7	Requires some support			
7	Not healthy / aged / disabled			
40	Requires continuous support / help			
67	Total incapacity to provide care			
67	Total burnout			
<input type="text"/>	Section 7 score			
0	TOTAL SCORE Section 6 + 7 "Carer"			

8. OTHER PERSONS INVOLVED IN ASSESSMENT			
*	Family practitioner		Physiotherapist
	District surgeon	*	Social worker
*	Nursing personnel		Old age home personnel
	Specialist geriatrician / psychiatrist		Care-giver
	Traditional healer		Home care personnel

SECTION 3: KEY TO ASSESSMENT FOR SERVICE REQUIREMENT				FINDINGS:			
Score from "Skilled" (Section 1)	32	0,2	6,4	Requires institutional care	Yes *		No
Score from "ADLs" (Section 2)	70	0,25	17,5	If Yes, Specify care type required :			
Score from "Mental" (Section 3)	23	1	23	Temporary		Permanent	
Score from "Primary" (Section 4)	0	0,15	0	Respite (care- giver relief)		Terminal	
Total score "Carer" (Section 6 & 7)	0	0,15	0	Rehabilitation			
DQ98 INDEX SCORE		Total	46,9				

Additional information :

SECTION 4: RECOMMENDATION:

Admission to home for the aged			Referral for community health services																																																																				
If Admission Recommended			Community services		Yes		No																																																																
Urgent			Medical services		Yes		No																																																																
As soon as possible			Geriatric services		Yes		No																																																																
Other:			Psychiatric services		Yes		No																																																																
Re-assess: Date:			Referred to:				Date:																																																																
Community support service recommendation:																																																																							
No additional support services recommended			Additional support by means of certain home care services																																																																				
Indicate which services are currently "in use" or "required":																																																																							
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SECTION 5: CONCLUSION OF ASSESSMENT

(Delete where appropriate)

Assessor: I have discussed the current assessment and recommendations with the applicant / care-giver and have indicated the right to appeal.

Signature:

Date:

Applicant / Caregiver: I have discussed the assessment, recommendations and appeal procedure with the assessor.

I agree / disagree with the recommendation.

I agree / disagree that the assessment form be referred to Community Services.

I agree / disagree that the assessment form be referred to the following organisation:

Motivate (if disagreement)

Signature:

Date:

Client referred to:

Date :